

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>15013 Bangor Dr.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Elizabeth Ambrose</u>				4. DATE OF DEATH Month Day Year <u>1 3 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26 1894</u>	9. AGE (In years lost birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward R. Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Ella Virginia Beck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>Virginia A. Huber, 5013 Bangor Dr.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>350x Parkinson's disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1-3-1954</u> to <u>1-3-1958</u> , that I last saw the deceased alive on <u>1-3-1958</u> , and that death occurred at <u>8:35 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>11622 Georgia Ave Silver Spring, Md.</u>				DATE SIGNED <u>1-3-59</u>			
ACTUAL SIGNATURE <u>Morris Perry</u>							
PHYSICIAN'S NAME (Type) <u>Morris Perry, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-7-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Ceme.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey, Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u></u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 24 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS 2705 Bellevue Avenue							
3. NAME OF DECEASED (Type or print) First Ruby Middle Fern Last Amburgey				4. DATE OF DEATH Month January Day 30 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 31, 1930	
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months 28 Days 28 Hours 28 Min. 28		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer		10b. KIND OF BUSINESS OR INDUSTRY Unascertainable	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Woodrow Amburgey		14. MOTHER'S MAIDEN NAME Arminta Combs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancerous of the ovary with 175.0 DUE TO widespread metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 yr							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 19 p. m. Month, Day, Year				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from January 6 , 19 59 , to January 30 , 19 59 , that I last saw the deceased alive on January 30 , 19 59 , and that death occurred at 7:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1-31-59 ACTUAL SIGNATURE James M. Marsh M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) James M. Marsh, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		2-3-59		Amburgey		Hindman Ky.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers & Inc. ADDRESS 1400 Chapin St. N.W. Wash. D.C.				24a. REC'D BY REGISTRAR DATE FEB 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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CERTIFICATE OF DEATH

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1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SERVICE		12. GRADE		13. PAY		14. DUTY		15. STATUS		16. GRADE		17. PAY		18. DUTY		19. STATUS		20. GRADE		21. PAY		22. DUTY		23. STATUS		24. GRADE		25. PAY		26. DUTY		27. STATUS		28. GRADE		29. PAY		30. DUTY		31. STATUS		32. GRADE		33. PAY		34. DUTY		35. STATUS		36. GRADE		37. PAY		38. DUTY		39. STATUS		40. GRADE		41. PAY		42. DUTY		43. STATUS		44. GRADE		45. PAY		46. DUTY		47. STATUS		48. GRADE		49. PAY		50. DUTY		51. STATUS		52. GRADE		53. PAY		54. DUTY		55. STATUS		56. GRADE		57. PAY		58. DUTY		59. STATUS		60. GRADE		61. PAY		62. DUTY		63. STATUS		64. GRADE		65. PAY		66. DUTY		67. STATUS		68. GRADE		69. PAY		70. DUTY		71. STATUS		72. GRADE		73. PAY		74. DUTY		75. STATUS		76. GRADE		77. PAY		78. DUTY		79. STATUS		80. GRADE		81. PAY		82. DUTY		83. STATUS		84. GRADE		85. PAY		86. DUTY		87. STATUS		88. GRADE		89. PAY		90. DUTY		91. STATUS		92. GRADE		93. PAY		94. DUTY		95. STATUS		96. GRADE		97. PAY		98. DUTY		99. STATUS		100. GRADE		101. PAY		102. DUTY		103. STATUS		104. GRADE		105. PAY		106. DUTY		107. STATUS		108. GRADE		109. PAY		110. DUTY		111. STATUS		112. GRADE		113. PAY		114. DUTY		115. STATUS		116. GRADE		117. PAY		118. DUTY		119. STATUS		120. GRADE		121. PAY		122. DUTY		123. STATUS		124. GRADE		125. PAY		126. DUTY		127. STATUS		128. GRADE		129. PAY		130. DUTY		131. STATUS		132. GRADE		133. PAY		134. DUTY		135. STATUS		136. GRADE		137. PAY		138. DUTY		139. STATUS		140. GRADE		141. PAY		142. DUTY		143. STATUS		144. GRADE		145. PAY		146. DUTY		147. STATUS		148. GRADE		149. PAY		150. DUTY		151. STATUS		152. GRADE		153. PAY		154. DUTY		155. STATUS		156. GRADE		157. PAY		158. DUTY		159. STATUS		160. GRADE		161. PAY		162. DUTY		163. STATUS		164. GRADE		165. PAY		166. DUTY		167. STATUS		168. GRADE		169. PAY		170. DUTY		171. STATUS		172. GRADE		173. PAY		174. DUTY		175. STATUS		176. GRADE		177. PAY		178. 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GRADE		265. PAY		266. DUTY		267. STATUS		268. GRADE		269. PAY		270. DUTY		271. STATUS		272. GRADE		273. PAY		274. DUTY		275. STATUS		276. GRADE		277. PAY		278. DUTY		279. STATUS		280. GRADE		281. PAY		282. DUTY		283. STATUS		284. GRADE		285. PAY		286. DUTY		287. STATUS		288. GRADE		289. PAY		290. DUTY		291. STATUS		292. GRADE		293. PAY		294. DUTY		295. STATUS		296. GRADE		297. PAY		298. DUTY		299. STATUS		300. GRADE		301. PAY		302. DUTY		303. STATUS		304. GRADE		305. PAY		306. DUTY		307. STATUS		308. GRADE		309. PAY		310. DUTY		311. STATUS		312. GRADE		313. PAY		314. DUTY		315. STATUS		316. GRADE		317. PAY		318. DUTY		319. STATUS		320. GRADE		321. PAY		322. DUTY		323. STATUS		324. GRADE		325. PAY		326. DUTY		327. STATUS		328. GRADE		329. PAY		330. DUTY		331. STATUS		332. GRADE		333. PAY		334. DUTY		335. STATUS		336. GRADE		337. PAY		338. DUTY		339. STATUS		340. GRADE		341. PAY		342. DUTY		343. STATUS		344. GRADE		345. PAY		346. DUTY		347. STATUS		348. GRADE		349. PAY		350. DUTY		351. STATUS		352. GRADE		353. PAY		354. DUTY		355. STATUS		356. GRADE		357. PAY		358. DUTY		359. STATUS		360. GRADE		361. PAY		362. DUTY		363. STATUS		364. GRADE		365. PAY		366. DUTY		367. STATUS		368. GRADE		369. PAY		370. DUTY		371. STATUS		372. GRADE		373. PAY		374. DUTY		375. STATUS		376. GRADE		377. PAY		378. DUTY		379. STATUS		380. GRADE		381. PAY		382. DUTY		383. STATUS		384. GRADE		385. PAY		386. DUTY		387. STATUS		388. GRADE		389. PAY		390. DUTY		391. STATUS		392. GRADE		393. PAY		394. DUTY		395. STATUS		396. GRADE		397. PAY		398. DUTY		399. STATUS		400. GRADE		401. PAY		402. DUTY		403. STATUS		404. GRADE		405. PAY		406. DUTY		407. STATUS		408. GRADE		409. PAY		410. DUTY		411. STATUS		412. GRADE		413. PAY		414. DUTY		415. STATUS		416. GRADE		417. PAY		418. DUTY		419. STATUS		420. GRADE		421. PAY		422. DUTY		423. STATUS		424. GRADE		425. PAY		426. DUTY		427. STATUS		428. GRADE		429. PAY		430. DUTY		431. STATUS		432. GRADE		433. PAY		434. DUTY		435. STATUS		436. GRADE		437. 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PAY		698. DUTY		699. STATUS		700. GRADE		701. PAY		702. DUTY		703. STATUS		704. GRADE		705. PAY		706. DUTY		707. STATUS		708. GRADE		709. PAY		710. DUTY		711. STATUS		712. GRADE		713. PAY		714. DUTY		715. STATUS		716. GRADE		717. PAY		718. DUTY		719. STATUS		720. GRADE		721. PAY		722. DUTY		723. STATUS		724. GRADE		725. PAY		726. DUTY		727. STATUS		728. GRADE		729. PAY		730. DUTY		731. STATUS		732. GRADE		733. PAY		734. DUTY		735. STATUS		736. GRADE		737. PAY		738. DUTY		739. STATUS		740. GRADE		741. PAY		742. DUTY		743. STATUS		744. GRADE		745. PAY		746. DUTY		747. STATUS		748. GRADE		749. PAY		750. DUTY		751. STATUS		752. GRADE		753. PAY		754. DUTY		755. STATUS		756. GRADE		757. PAY		758. DUTY		759. STATUS		760. GRADE		761. PAY		762. DUTY		763. STATUS		764. GRADE		765. PAY		766. DUTY		767. STATUS		768. GRADE		769. PAY		770. DUTY		771. STATUS		772. GRADE		773. PAY		774. DUTY		775. STATUS		776. GRADE		777. PAY		778. DUTY		779. STATUS		780. GRADE		781. PAY		782. DUTY		783. STATUS		784. GRADE		785. PAY		786. DUTY		787. STATUS		788. GRADE		789. PAY		790. DUTY		791. STATUS		792. GRADE		793. PAY		794. DUTY		795. STATUS		796. GRADE		797. PAY		798. DUTY		799. STATUS		800. GRADE		801. PAY		802. DUTY		803. STATUS		804. GRADE		805. PAY		806. DUTY		807. STATUS		808. GRADE		809. PAY		810. DUTY		811. STATUS		812. GRADE		813. PAY		814. DUTY		815. STATUS		816. GRADE		817. PAY		818. DUTY		819. STATUS		820. GRADE		821. PAY		822. DUTY		823. STATUS		824. GRADE		825. PAY		826. DUTY		827. STATUS		828. GRADE		829. PAY		830. DUTY		831. STATUS		832. GRADE		833. PAY		834. DUTY		835. STATUS	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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301
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence, before admission) a. STATE Florida b. COUNTY Monroe			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN lb 33 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Doris Louise ANDREWS				4. DATE OF DEATH Month Day Year January 21 19 59			
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-5-20	9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Iowa	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Everett STICE				14. MOTHER'S MAIDEN NAME Aorende KLEIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, sigmoid colon 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH appr. 1 yr.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 19, 19 58 to January 21, 19 59 , that I last saw the deceased alive on January 21, 19 59 , and that death occurred at 3:37 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NMMC 1-22-59 ACTUAL SIGNATURE Larry J. Hines M.D. PHYSICIAN'S NAME (Type) Larry J. HINES, LCDR, MC, USN Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 1-23-59		22b. DATE THEREOF 1-23-59		22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) (State) Keokuk Iowa	
23. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home, 4748 Wisc. Ave., NW, Wash. DC ADDRESS				24a. REC'D BY REGISTRAR JAN 26 '59 DATE		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

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TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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302
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 16 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Kings c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ New York - Brooklyn d. STREET ADDRESS 1758 56th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Magdalena Last ATORIA			4. DATE OF DEATH Month January Day 8 Year 19 59				
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 12-17-58		9. AGE (In years last birthday) yrs. 22		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 22 Days 22 Hours 22 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) Guantanamo Bay, Cuba		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Joseph A. ATORIA				
14. MOTHER'S MAIDEN NAME Margo MARQUEC			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				
16. SOCIAL SECURITY NO. None			17. INFORMANT Official Navy Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7547 Cyanotic heart disease, congenital DUE TO (b) Pulmonary stenosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I attended the deceased from December 23, 19 58 , to January 8, 19 59 , that I last saw the deceased alive on January 8, 19 59 , and that death occurred at 9:10A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE H. L. Walton		M.D. U. S. Naval Hospital, NNM		DATE SIGNED 1-8-59			
PHYSICIAN'S NAME (Type) H. L. WALTON, LT, MC, USN		Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-12-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National			
22d. LOCATION (City, town, or county) Arlington		22e. (State) Virginia		22f. REC'D BY REGISTRAR JAN 12 '59			
23. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home, 4748 Wisc. Ave., NW, Washington D.C.		23b. ADDRESS D. C.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>184 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hosp</u>				d. STREET ADDRESS <u>1388 Tuckerman St N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rebecca</u> Middle <u>—</u> Last <u>Auerbach</u>				4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>Jewish</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-28-92</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Schenkman</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Son - Wash. San + Hosp record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE, COMPENSATED</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>GENERALIZED ARTERIOSCLEROSIS WITH PARKINSONISM</u> YEARS. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October</u> , 19 <u>58</u> , to <u>Jan 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 13</u> , 19 <u>59</u> , and that death occurred at <u>1:26 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.W.D. Anish</u>				ADDRESS (Street, city or town, state) <u>927 Rushing St</u>		DATE SIGNED <u>1-14-59</u>	
PHYSICIAN'S NAME (Type) <u>A.W.D. ANISH</u>				<u>Silva Spum Mel</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sec. Wash. New Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>				ADDRESS <u>4217 9th St NW Wash D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
24a. REC'D BY REGISTRAR <u>—</u>				DATE <u>JAN 15 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00768

757

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>3mo. 4days 56</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>8658 Piney Branch Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William Joseph</u> Middle <u>I</u> Last <u>Baker</u>				4. DATE OF DEATH Month <u>January</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-28-09</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Sub. Sanitary Comm.</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Edward Baker</u>				14. MOTHER'S MAIDEN NAME <u>Mary Gossner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>214-01-0323</u>		17. INFORMANT <u>Hospital Record</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>11 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>January 1956</u> , to <u>January 30, 1959</u> , that I last saw the deceased alive on <u>January 30, 1959</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Boris Rabkin</u>				ADDRESS (Street, city or town, state) <u>1019 University Boulevard Silver Spring, Md.</u> DATE SIGNED <u>1/30/59</u>			
PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB. 2/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WASH. NATL. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>SWITLAND & Goss Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Charles Co. Annapolis, Md.</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR DATE <u>FEB 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kruer</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 10

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

803

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	c. LENGTH OF STAY IN 1b <u>3 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If in hospital, give street address) <u>DAUPHINE</u> <u>13301 Dauphin St.</u>		d. STREET ADDRESS <u>DAUPHINE</u> <u>13301 Dauphin St</u>	
3. NAME OF DECEASED (Type or print) <u>Earl Jefferson Baldwin</u>		4. DATE OF DEATH <u>Jan 5- 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-16</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing Supplies</u>	
11. BIRTHPLACE (State or foreign country) <u>va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alfred Baldwin</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Hubbard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WW # 2 225-10-6596</u>	
17. INFORMANT <u>Ruth Baldwin (wife)</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>976X Thoracic Hemorrhage</u> DUE TO (b) <u>shot gun wound in left chest (heart)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Self inflicted shot gun wound</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>1-5-1959</u>		20d. INJURY OCCURRED <u>Home</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Silver Spring Monty md</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Jan 5-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/9/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>JAN 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hand</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00770

804

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 SILVER SPRING</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>SEYMOUR NURSING HOME</i>		d. STREET ADDRESS <i>15005 ARGYLE CLUB RD.</i>	
3. NAME OF DECEASED (Type or print) First <i>EMMA</i> Middle <i>MAY</i> Last <i>BARROWS</i>		4. DATE OF DEATH Month <i>JAN.</i> Day <i>25</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JUL. 13, 1868</i>
9. AGE (In years last birthday) <i>90</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Homemaker</i>	
11. BIRTHPLACE (State or foreign country) <i>TRENTON, N. J.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John C. Tabram</i>		14. MOTHER'S MAIDEN NAME <i>Emma Wheatland</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>W</i>	
17. INFORMANT <i>Mr. Joseph G. Bland, 6411 Highland Hk. Chch Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CERERAL THROMOSIS</i> <i>332X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>GENERIZED ARTERIOSCLEROSIS</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 20, 1959</i> , to <i>Jan 25, 1959</i> , that I last saw the deceased alive on <i>Jan. 23, 1959</i> , and that death occurred at <i>4 A. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Eino Magi</i>		DATE SIGNED <i>1/25/59</i>	
PHYSICIAN'S NAME (Type) <i>EINO MAGI</i>		<i>Silver Spring, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan. 28, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Colonial Memorial Park</i>		22d. LOCATION (City, town, or county) (State) <i>Trenton, New Jersey</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		ADDRESS <i>254 Canal Street DC</i>	
24a. REC'D BY REGISTRAR <i>DATE JAN 27 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00771

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> 805 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4701 Adrian St</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Garnett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantville</u> <u>11 X - 2</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eva May Beachy</u> First Middle Last 4. DATE OF DEATH <u>Jan 6 1959</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>12-8-1879</u> 9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Gilead Broadwater</u> 14. MOTHER'S MAIDEN NAME <u>Aida Maust</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>James C. Beachy (son)</u> Address <u>Stein 1</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Bloeschert</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. Bloeschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Jan 6 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 9, 1959</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Grantville</u> 22d. LOCATION (City, town, or county) (State) <u>Grantville, Md.</u>	
23. BURIAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Washington D.C.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>JAN 9 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF
NEW YORK

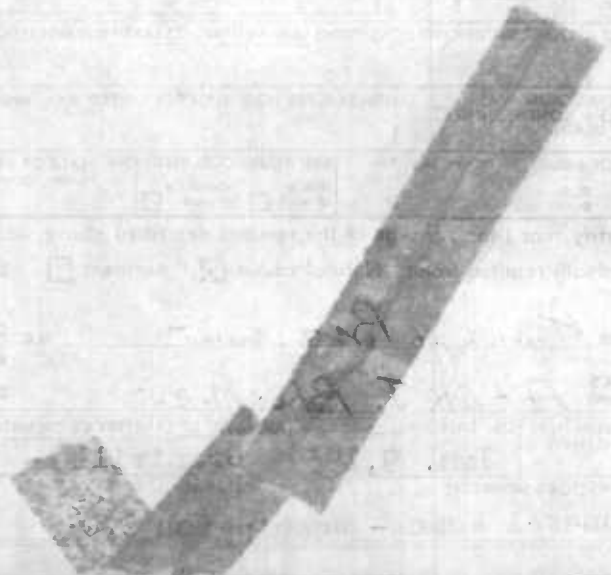
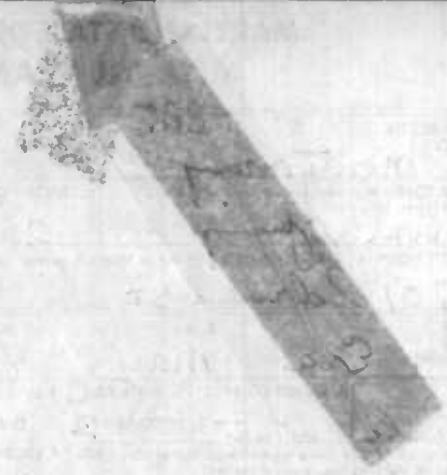


IN SENATE,
January 1, 1914.

REPORT OF THE
COMMISSIONER OF
THE STATE OF NEW YORK,
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1913.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
STATE OF NEW YORK
BUREAU OF VITAL STATISTICS



806

CERTIFICATE OF DEATH

00772

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASH.		b. COUNTY D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington, Md.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) Kensington Gardens Sant.				d. STREET ADDRESS 1840 BILTMORE ST. N.W. WASH. D.C.			
3. NAME OF DECEASED (Type or print) First Middle Last Elmer L. Beales				4. DATE OF DEATH Month Day Year JAN. 4 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 5, 1883	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOORMAN - COL. TAFT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID HENRY BEALES				14. MOTHER'S MAIDEN NAME ANNA REBECCA THOMPSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-40-6100		17. INFORMANT Address REBECCA LA FUERNE (DAUGHTER)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary metastases and 197X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized metastases DUE TO (c) Cancer of Prostate						INTERVAL BETWEEN ONSET AND DEATH 6 months 4 mos + 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1958 , to Jan 4 1959 , that I last saw the deceased alive on Jan 3 1959 , and that death occurred at 5:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5000 DONT PLACE, NW WASH. D.C. DATE SIGNED Jan 4/1959 ACTUAL SIGNATURE Stephen Hulburt M.D. PHYSICIAN'S NAME (Type) R. Stephen Hulburt, M.D. Washington, D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/6/59		22c. NAME OF CEMETERY OR CREMATORY Lakeview Cemetery		22d. LOCATION (City, town, or county) (State) Hamilton, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee Son				ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR DATE JAN 6 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

807

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Wash. DC</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47x-9 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Conv. Home</u> <u>9200 Old Georgetown Rd.</u>				d. STREET ADDRESS <u>4104 Harrison St NW</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah C. Beaver</u>				4. DATE OF DEATH Month Day Year <u>Jan. 30 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 9, 1883</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>School teacher</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Joseph Lepny</u>				14. MOTHER'S MAIDEN NAME <u>Florance Oldt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Arthur L. Beaver, 4104 Harrison St NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 mos.</u> years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 4</u> , 19 <u>57</u> , to <u>Jan 30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 29</u> , 19 <u>59</u> , and that death occurred at <u>10:36</u> P.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Robert B. Havell</u>				M.D. <u>5516 Nebraska Ave DC 1-30-59</u>			
PHYSICIAN'S NAME (Type) <u>Robert B. Havell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Kratzville Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Kratzville Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>				ADDRESS <u>5103 21st Ave NW</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 4 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Beaver</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

758

CERTIFICATE OF DEATH

00774

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle HUNEKE Last BEERS				4. DATE OF DEATH Month JAN. Day 26 Year 19 59			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/10/07	
9. AGE (In years last birthday) yrs. 51		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) COLORADO	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES J. HUNEKE				14. MOTHER'S MAIDEN NAME MARY THOMPSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		17. INFORMANT Address Miss Cecelia Huneke, 1301 15th St., N.W. Washington, D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage (massive) 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension, systemic DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							INTERVAL BETWEEN ONSET AND DEATH 10 hours. Unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 24 , 19 56 , to Jan 26 , 19 59 , that I last saw the deceased alive on Jan 26 , 19 59 , and that death occurred at 5:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Aaron H. Traum				ADDRESS (Street, city or town, state) 8237 Georgia Ave Silver Spring, Md.			
DATE SIGNED 1-27-59							
PHYSICIAN'S NAME (Type) AARON H. TRAUM							
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		22b. DATE THEREOF 1/31/59		22c. NAME OF CEMETERY OR CREMATORY EVERGREEN CEMETERY		22d. LOCATION (City, town, or county) (State) COLORADO SPRINGS, COLORADO	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. POMPHREY, INC. Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24c. REC'D BY REGISTRAR DATE JAN 28 '59	
24b. REGISTRAR'S SIGNATURE Carlton S. Traut							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00775

Reg. Dist. No.

790

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>	
c. LENGTH OF STAY IN 1b <u>6 weeks</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1710 Usher Mill Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <u>1710 Usher Mill Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Jeffrey Robert Behanna</u>		4. DATE OF DEATH <u>Jan 23 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-16-58</u>
9. AGE (In years last birthday) <u>26</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clyde Behanna</u>		14. MOTHER'S MAIDEN NAME <u>Rita Stofko</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Clyde Behanna -</u>		Address <u>Stim 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>1-23-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/26/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>JAN 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home or, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF
NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS - CERTIFICATE OF DEATH

DEPT. OF HEALTH
BUREAU OF MEDICAL EXAMINERS

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

TEMPERATURE

PULSE

BLOOD PRESSURE

WEIGHT

HEIGHT

HAIR

EYES

NOSE

MOUTH

THROAT

STOMACH

INTESTINES

BLADDER

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PROSTATE

UTERUS

VAGINA

TESTES

EPIDIDYMIS

SCROTUM

PENIS

CLITORIS

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808
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>49 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Cambria</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nettleton</u> d. STREET ADDRESS <u>Box 11</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ronald Joseph Behory</u>			4. DATE OF DEATH Month Day Year <u>January 23, 19 59</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10, 1950</u>		9. AGE (In years last birthday) <u>8</u> yrs. <u>10</u> Months <u>13</u> Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>John Behory</u>				
14. MOTHER'S MAIDEN NAME <u>Doris Gore</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Staphylococcal Meningitis and Septicemia</u> <u>340.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Lymphocytic Leukemia</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Epidermolysis Bullosa</u>							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <u>Bethesda</u>		20g. (County) <u>Montgomery</u>		20h. (State) <u>Md.</u>			
21. I certify that I attended the deceased from <u>December 5, 19 58</u> , to <u>January 23, 19 59</u> , that I last saw the deceased alive on <u>January 23, 19 59</u> , and that death occurred at <u>5:20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>1-23-59</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>							
ACTUAL SIGNATURE <u>Arthur T. Teplitzky</u>		M.D. <u>Arthur T. Teplitzky, M.D.</u>					
PHYSICIAN'S NAME (Type) <u>Arthur T. Teplitzky, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-27-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pike Brethern Cem.</u>			
22d. LOCATION (City, town, or county) <u>Cambria Co., Penna.</u>		(State) <u>Penn.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda 14, Md.</u>			ADDRESS <u>Bethesda 14, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 26 '59</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneale</u>							

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

809

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5402 Lambeth Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Jane Montgomery Birgfeld				4. DATE OF DEATH Month Day Year January 27, 1959			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/17/80	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Charles Montgomery			14. MOTHER'S MAIDEN NAME Alice M. Cole				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Kenneth Birgfeld 5116 Westridge Rd. Westhaven, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Thrombosis (c) Cardio-vascular-renal Disease INTERVAL BETWEEN ONSET AND DEATH 4 hours 4 wks 6 years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/28 , 19 58 , to 1/27 , 19 59 , that I last saw the deceased alive on 1/24 , 19 59 , and that death occurred at 9:50 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank Y. Jagers, Jr. M.D.				ADDRESS (Street, city or town, state) 5707 Wisconsin Ave DATE SIGNED 1/27/59			
PHYSICIAN'S NAME (Type) Frank Y. Jagers, Jr.				Cherry Chase 15, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/29/59		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince George, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington 9, D.C.				24a. REC'D BY REGISTRAR DATE JAN 28 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00778

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery M		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 32 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		d. STREET ADDRESS 3719 Bradley Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SARA		First		Middle V		Last BLACKISTONE		4. DATE OF DEATH Month January Day 28 Year 59					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 13, 1874		9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months 5 Days 13		IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Edmond Gaines Wheeler		14. MOTHER'S MAIDEN NAME Sarah Murray											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Z.D. Blackistone, Jr.		Address Son-Bethesda, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 weeks											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April , 19 55 , to Jan 28 , 19 59 , that I last saw the deceased alive on Jan 17 , 19 59 , and that death occurred at 1:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Paul D. Cantor M.D. 4109 Montgomery - Bethesda, Md.		DATE SIGNED Jan 28, 1959									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/30/59		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) Washington, D. C.							
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE FEB 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kiara							

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CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 35 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1925 Beltmore Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Daniel BLUNDELL			4. DATE OF DEATH Month Day Year January 19 1959		
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-8-99		9. AGE (In years lost birthday) 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Joseph BLUNDELL		
14. MOTHER'S MAIDEN NAME Elizabeth JARMAN			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WWII		
16. SOCIAL SECURITY NO. 579-42-8457			17. INFORMANT Official Navy Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 Bronchogenic Carcinoma with metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Terminal diffuse pneumonitis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH approx 6 months approx 1 week
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from December 15, 1958 , to January 19, 1959 , that I last saw the deceased alive on January 19, 1959 , and that death occurred at 1:40 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 1-19-59					
ACTUAL SIGNATURE Jerome A. Gold M.D. U. S. Naval Hospital 1-19-59					
PHYSICIAN'S NAME (Type) Jerome A. GOLD, LT, MC, USN Bethesda, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-23-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) Arlington		(State) Va.		24a. REC'D BY REGISTRAR JAN 22 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume		24c. REGISTRAR'S SIGNATURE Arthur S. Hume			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Date of registration		12. Place of registration	
13. Name of informant		14. Address of informant		15. Telephone number		16. Name of hospital	
17. Name of funeral home		18. Address of funeral home		19. Telephone number		20. Name of cemetery	
21. Address of cemetery		22. Name of burial place		23. Address of burial place		24. Name of burial place	
25. Name of burial place		26. Address of burial place		27. Name of burial place		28. Address of burial place	
29. Name of burial place		30. Address of burial place		31. Name of burial place		32. Address of burial place	
33. Name of burial place		34. Address of burial place		35. Name of burial place		36. Address of burial place	
37. Name of burial place		38. Address of burial place		39. Name of burial place		40. Address of burial place	
41. Name of burial place		42. Address of burial place		43. Name of burial place		44. Address of burial place	
45. Name of burial place		46. Address of burial place		47. Name of burial place		48. Address of burial place	
49. Name of burial place		50. Address of burial place		51. Name of burial place		52. Address of burial place	
53. Name of burial place		54. Address of burial place		55. Name of burial place		56. Address of burial place	
57. Name of burial place		58. Address of burial place		59. Name of burial place		60. Address of burial place	
61. Name of burial place		62. Address of burial place		63. Name of burial place		64. Address of burial place	
65. Name of burial place		66. Address of burial place		67. Name of burial place		68. Address of burial place	
69. Name of burial place		70. Address of burial place		71. Name of burial place		72. Address of burial place	
73. Name of burial place		74. Address of burial place		75. Name of burial place		76. Address of burial place	
77. Name of burial place		78. Address of burial place		79. Name of burial place		80. Address of burial place	
81. Name of burial place		82. Address of burial place		83. Name of burial place		84. Address of burial place	
85. Name of burial place		86. Address of burial place		87. Name of burial place		88. Address of burial place	
89. Name of burial place		90. Address of burial place		91. Name of burial place		92. Address of burial place	
93. Name of burial place		94. Address of burial place		95. Name of burial place		96. Address of burial place	
97. Name of burial place		98. Address of burial place		99. Name of burial place		100. Address of burial place	

[Handwritten signature]

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CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 60 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chevy Chase d. STREET ADDRESS 5077 Bradley Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Samuel James BONNER			4. DATE OF DEATH Month Day Year January 19 19 59				
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-99	9. AGE (In years lost birthday) yrs. 59	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Scotland			
13. FATHER'S NAME Frederick BONNER			14. MOTHER'S MAIDEN NAME Fannie BARNES				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Margaret Bonner (W), same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 430.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aortic insufficiency DUE TO Arteriosclerotic heart disease (c) Subacute bacterial endocarditis					INTERVAL BETWEEN ONSET AND DEATH 14 hours 3 weeks Indef. 3 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from November 20, 1958 , to January 19, 1959 , that I last saw the deceased alive on January 19, 1959 , and that death occurred at 2:45 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NMMC 1-20-59							
ACTUAL SIGNATURE J. T. Horgan		M.D. U. S. Naval Hospital, NMMC 1-20-59					
PHYSICIAN'S NAME (Type) J. T. HORGAN, LCDR, MC, USN		Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-22-59	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county)	(State) Va.			
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey			ADDRESS Bethesda, Md.	24a. REC'D BY REGISTRAR DATE JAN 22 59	24b. REGISTRAR'S SIGNATURE John S. Hinkle		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		1910		Maryland	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Catholic	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
1950		10:00 AM		Home		Dr. Smith		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Potomac		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 26	
d. NAME OF HOSPITAL (If not in hospital, give street address) Ropin Rest Home		d. STREET ADDRESS 10501 Old Georgetown Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Laura B. Bortz First Middle Last		4. DATE OF DEATH January 10, 1959 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 19, 1877
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 11 Days 21	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Philip Markley		14. MOTHER'S MAIDEN NAME Hettie Bossert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Nelson M. Bortz-Item # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure - 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis & convulsions - 36 hr. DUE TO (c) Arterio Sclerosis generalized - 20 yr.		INTERVAL BETWEEN ONSET AND DEATH 36 hr. 36 hr. 20 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 1951 , to date , 19 59 , that I last saw the deceased alive on 10 Jan , 19 59 , and that death occurred at 4:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7936 Old Georgetown Road, Bethesda, Md. DATE SIGNED 1/10/59			
ACTUAL SIGNATURE John G. Ball M.D.			
PHYSICIAN'S NAME (Type) John G. Ball		7936 Old Georgetown Road, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/14/59	22c. NAME OF CEMETERY OR CREMATORY Schwenksville, Cemetery	22d. LOCATION (City, town, or county) (State) Schwenksville, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JAN 14 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Frank

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00783

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 158 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chicago 51X-3	
3. NAME OF DECEASED (Type or print) First Middle Last Charles Vernon Bowles		4. DATE OF DEATH Month Day Year January 16, 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 18, 1896
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY (Unknown)	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William A. Bowles		14. MOTHER'S MAIDEN NAME Mary L. Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 335-01-7313	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mycosis Fungoides 205X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Massive Pulmonary Involvement DUE TO (c) Chronic Lung Disease-Bronchiectasis & Emphysema INTERVAL BETWEEN ONSET AND DEATH Years Weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 11, 1958 , to January 16, 1959 , that I last saw the deceased alive on January 16, 1959 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul Schwab, M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
DATE SIGNED 1-16-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Transit-Burial 1-17-59		22b. DATE THEREOF Washington Park Cem.	
22c. NAME OF CEMETERY OR CREMATORY Indianapolis, Indiana		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE JAN 20 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF INDIANA DEPARTMENT OF HEALTH-BALTIMORE 10

Name of Deceased		Robert A. Murphy	
Age		35	
Sex		Male	
Race		White	
Date of Death		October 1, 1935	
Place of Death		The Clinical Center, Indianapolis, Indiana	
Cause of Death		Myocardial Infarction	
Occupation		Engineer	
Residence		Indianapolis, Indiana	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		October 1, 1935	
Place of Registration		Indianapolis, Indiana	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00784

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 500 Blk. Park Pl.			e. STREET ADDRESS 4610 Overbrook Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ELMER H BRIENT			4. DATE OF DEATH January 13 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 29, 1892		9. AGE (In years last birthday) 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Theater		10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME John Brient		
14. MOTHER'S MAIDEN NAME Unknown			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Theodore C Brient-son-as item 2d		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH sudden
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-13-59	
EXAMINER'S NAME (Type) FRANK J. Broschert		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/16/59		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	
22d. LOCATION (City, town, or county) Rockville, Maryland		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey			ADDRESS Bethesda, Maryland		
24a. REC'D BY REGISTRAR Jan 16 59			24b. REGISTRAR'S SIGNATURE Arthur S. Howard		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

817

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>M</u>				6. COLOR OR RACE <u>W</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>Oct 4 1885</u>			
9. AGE (In years last birthday) <u>73</u> yrs.				10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>29</u> Hours <u></u> Min. <u></u>			
11. BIRTHPLACE (State or foreign country) <u>Newark N.Y.</u>				12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>			
13. FATHER'S NAME <u>Morris Eugene Briggs</u>				14. MOTHER'S MAIDEN NAME <u>Jane Rodgers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-10-6652-A</u>			
17. INFORMANT <u>John Briggs, wife</u>				Address <u>Bethesda, Md. 4531 Middleton Lane</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction.</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 24, 1958</u> to <u>Dec 26, 1958</u> , that I last saw the deceased alive on <u>Dec 26, 1958</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Hernandez</u>				ADDRESS (Street, city or town, state) <u>1506 17th St N.W.</u>			
PHYSICIAN'S NAME (Type) <u>JOHN HERNANDEZ</u>				DATE SIGNED <u>1-3-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>1/5/59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>				22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 7 '59</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kears</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

818

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Delaware			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 14 hrs. 40 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kirklyn 75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				d. STREET ADDRESS 131 Cunningham Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah		First Emma		Last Brooks		4. DATE OF DEATH Month January Day 15 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1882		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edwin Riley				14. MOTHER'S MAIDEN NAME Sarah Ambler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. N6		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO acute pulmonary edema Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) congestive heart failure (c) coronary insufficiency							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intestinal obstruction							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1958 to 1/15/1959 , that I last saw the deceased alive on Jan 15, 1959 , and that death occurred at 1:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE L. I. Leal M.D.				PHYSICIAN'S NAME (Type) L. I. Leal, M. D., Gaithersburg, Maryland 1.15.59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan, 19		22c. NAME OF CEMETERY OR CREMATORY Holy Cross		22d. LOCATION (City, town, or county) (State) Lansdown Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber ADDRESS Laytonsville, Md.				24a. REC'D BY REGISTRAR JAN 19 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 100

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of burial place		18. Signature of burial place		19. Signature of burial place		20. Signature of burial place	
21. Signature of burial place		22. Signature of burial place		23. Signature of burial place		24. Signature of burial place	
25. Signature of burial place		26. Signature of burial place		27. Signature of burial place		28. Signature of burial place	
29. Signature of burial place		30. Signature of burial place		31. Signature of burial place		32. Signature of burial place	
33. Signature of burial place		34. Signature of burial place		35. Signature of burial place		36. Signature of burial place	
37. Signature of burial place		38. Signature of burial place		39. Signature of burial place		40. Signature of burial place	
41. Signature of burial place		42. Signature of burial place		43. Signature of burial place		44. Signature of burial place	
45. Signature of burial place		46. Signature of burial place		47. Signature of burial place		48. Signature of burial place	
49. Signature of burial place		50. Signature of burial place		51. Signature of burial place		52. Signature of burial place	
53. Signature of burial place		54. Signature of burial place		55. Signature of burial place		56. Signature of burial place	
57. Signature of burial place		58. Signature of burial place		59. Signature of burial place		60. Signature of burial place	
61. Signature of burial place		62. Signature of burial place		63. Signature of burial place		64. Signature of burial place	
65. Signature of burial place		66. Signature of burial place		67. Signature of burial place		68. Signature of burial place	
69. Signature of burial place		70. Signature of burial place		71. Signature of burial place		72. Signature of burial place	
73. Signature of burial place		74. Signature of burial place		75. Signature of burial place		76. Signature of burial place	
77. Signature of burial place		78. Signature of burial place		79. Signature of burial place		80. Signature of burial place	
81. Signature of burial place		82. Signature of burial place		83. Signature of burial place		84. Signature of burial place	
85. Signature of burial place		86. Signature of burial place		87. Signature of burial place		88. Signature of burial place	
89. Signature of burial place		90. Signature of burial place		91. Signature of burial place		92. Signature of burial place	
93. Signature of burial place		94. Signature of burial place		95. Signature of burial place		96. Signature of burial place	
97. Signature of burial place		98. Signature of burial place		99. Signature of burial place		100. Signature of burial place	

1000

1000

1000

1000

00787

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville		d. STREET ADDRESS 13 Norbeck Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montg. Co. General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mary M Burroughes		4. DATE OF DEATH Month 1 Day 30 Year 1958					
5. SEX Female		6. COLOR OR RACE White		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 24, 1877	
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 6 Days 6 Hours Min. 		11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington D. C		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Eastwood-daughter-same as 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EMBOLUS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE 20 YRS DUE TO (c) CORONARY INFARCTION 24 HOURS		INTERVAL BETWEEN ONSET AND DEATH ONE HOUR					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 30, 1959 , to JAN 30, 1959 , that I last saw the deceased alive on JAN 30, 1959 , and that death occurred at 7 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 26 N. Summit Ave		DATE SIGNED Jan 30, 1959			
ACTUAL SIGNATURE Gordon S Rosenberger		M.D. Gordon S Rosenberger					
PHYSICIAN'S NAME (Type) Gordon S Rosenberger		ADDRESS Bethesda, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/3/59		22c. NAME OF CEMETERY OR CREMATORY Rockville		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE FEB 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

VS A15 (4)
JSM 10/57

VS A15 (4)
ISM 10/57

820

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Tennessee</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>33 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nashville</u> 79X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>			d. STREET ADDRESS <u>924 North Fifth Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lannie</u> Middle <u>Leo</u> Last <u>Buterbaugh</u>			4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>August 3, 1936</u>		9. AGE (In years last birthday) <u>22</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Alexander Clyde Buterbaugh</u>			14. MOTHER'S MAIDEN NAME <u>Rose Hicks</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unascertainable</u>	17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency, Anoxia and Cardiac Arrest</u> 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congenital Heart Disease.</u> DUE TO <u>Surgical Repair of Congenital Heart Disease using</u> (c) <u>Extracorporeal Circulation.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hr.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>December 7, 1958</u> to <u>January 9, 1959</u> , that I last saw the deceased alive on <u>January 9, 1959</u> , and that death occurred at <u>6:30p</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>William P. Cornell</u>		ADDRESS (Street, city or town, state) <u>The Clinical Center</u>		DATE SIGNED <u>1/10/59</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM P. CORNELL, M.D.</u>		ADDRESS <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-10-59</u>	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Nashville Tennessee</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co., Inc.</u>		ADDRESS <u>1400 Chapin St. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 13 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

821
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS <u>Route #3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clytis</u> Middle <u>Lena</u> Last <u>Butt</u>				4. DATE OF DEATH Month <u>January</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1, 1923</u>	
9. AGE (In years last birthday) <u>35</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>			
13. FATHER'S NAME <u>Edward Graham</u>				14. MOTHER'S MAIDEN NAME <u>Flossie Collins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Hospital Records</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>175.0 Carcinomatosis</u> DUE TO <u>Adeno Carcinoma left ovary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Not known</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				21. I certify that I attended the deceased from <u>Dec 30, 1958</u> to <u>Jan 19, 1959</u> , that I last saw the deceased alive on <u>Jan 18, 1959</u> , and that death occurred at <u>12:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jack Schumacher</u> M.D.				ADDRESS (Street, city or town, state) <u>Gaithersburg, Md.</u> DATE SIGNED <u>1-19-59</u>			
PHYSICIAN'S NAME (Type) <u>Jack Schumacher, M. D.</u>				ADDRESS <u>Gaithersburg, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-21-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barber</u> ADDRESS <u>Barber Laytonsville, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 23 59</u> DATE <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BOSTON

MADE IN U.S.A.

PAID COLLECTOR
BANK OF AMERICA

<p>1. Name of deceased (Print or write full name) _____</p>		<p>2. Sex (Male or Female) _____</p>	
<p>3. Date of birth (Month, day, year) _____</p>		<p>4. Place of birth (City, State, Country) _____</p>	
<p>5. Date of death (Month, day, year) _____</p>		<p>6. Place of death (City, State, Country) _____</p>	
<p>7. Cause of death (State immediately preceding condition, then the cause of death) _____</p>		<p>8. Signature of attending physician (Print name and sign) _____</p>	
<p>9. Signature of registrar (Print name and sign) _____</p>		<p>10. Signature of informant (Print name and sign) _____</p>	
<p>11. Signature of medical examiner (Print name and sign) _____</p>		<p>12. Signature of coroner (Print name and sign) _____</p>	
<p>13. Signature of funeral director (Print name and sign) _____</p>		<p>14. Signature of undertaker (Print name and sign) _____</p>	
<p>15. Signature of physician (Print name and sign) _____</p>		<p>16. Signature of nurse (Print name and sign) _____</p>	
<p>17. Signature of pharmacist (Print name and sign) _____</p>		<p>18. Signature of dentist (Print name and sign) _____</p>	
<p>19. Signature of veterinarian (Print name and sign) _____</p>		<p>20. Signature of other health officer (Print name and sign) _____</p>	

822 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. STREET ADDRESS <u>7204 Exfair Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Joseph Caldwell</u>				4. DATE OF DEATH Month Day Year <u>January 18 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 24, 1905</u>	
9. AGE (In years lost birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>1 24</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Heating Equip.</u>	
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Caldwell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Agnes Gibson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Helen Caldwell</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>15 hours</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>April 1952</u> to <u>January 18, 1959</u> , that I last saw the deceased alive on <u>January 18, 1959</u> , and that death occurred at <u>2:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Roger Kurtz</u>				DATE SIGNED <u>1-18-59</u>			
PHYSICIAN'S NAME (Type) <u>C. Roger Kurtz</u>				ADDRESS (Street, city or town, state) <u>3701 Conn Ave. NW, Wash 8, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 21, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>Jan 20 1959</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00791

Item 18 Film 238 1-23-59 ams

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>45 hrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>City 24</u>			
3. NAME OF DECEASED (Type or print) <u>Benjamin Franklin Calhoun</u> First Middle Last				4. DATE OF DEATH Month <u>1</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-15-88</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>23</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Jack Calhoun</u>				14. MOTHER'S M maiden NAME <u>Sarah Frye</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital Records</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>527.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>respiratory obstruction</u> DUE TO (c) <u>--</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma floor mouth</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/6, 1959</u> to <u>1/8, 1959</u> , that I last saw the deceased alive on <u>1/8, 1959</u> , and that death occurred at <u>5:40 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>931 Pershing Dr. S. S. Md.</u> DATE SIGNED <u>1/8/59</u>							
ACTUAL SIGNATURE <u>Bernard Kiploff</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. Bernard Kiploff - 931 Pershing Dr., Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR <u>Jan 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

WILLIAM E. ROND

Name of Deceased		WILLIAM E. ROND	
Date of Death		JAN 10 1950	
Place of Death		BALTIMORE, MARYLAND	
Cause of Death		HEART DISEASE	
Age at Death		65	
Sex		MALE	
Race		WHITE	
Marital Status		MARRIED	
Occupation		FARMER	
Residence		BALTIMORE, MARYLAND	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		JAN 10 1950	
Place of Registration		BALTIMORE, MARYLAND	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>—</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
c. LENGTH OF STAY IN 1b <u>40 days</u>				d. STREET ADDRESS <u>3810 Davis Pl. N.W.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Celia</u> First <u>W.H.H.</u> Middle <u>Caplan</u> Last				4. DATE OF DEATH Month <u>1</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-22-01</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary--Health Ed. & Welfare--DC</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mass.</u>		11. BIRTHPLACE (State or foreign country) <u>America</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Israel Caplan</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Goldman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>577-429838</u>			
17. INFORMANT <u>Hospital Records.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leiomyosarcoma of Liver</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-1</u> , 19 <u>58</u> , to <u>1-3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-1-59</u> , 19 <u>—</u> , and that death occurred at <u>6</u> AM, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Bernard H. Ostrow</u> M.D. <u>7961 Eastern Ave S.S. Md</u>							
PHYSICIAN'S NAME (Type) <u>BERNARD H. OSTROW</u>				<u>7961 EASTERN AVE. S.S. MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>1-4-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Highland Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Church, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>				24a. REC'D BY REGISTRAR <u>4217-9102 P.O. W.</u>		24b. REGISTRAR'S SIGNATURE	
DATE <u>JAN 6 '59</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF INTERMENT [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF JUDGE [Faint text]		SIGNATURE OF SHERIFF [Faint text]	

This certificate is to be filled out by the physician or other person who has attended the deceased, or by the coroner or other person who has examined the body, or by the undertaker or other person who has been in attendance at the death. It is to be filled out as soon as possible after the death, and before the body is buried or cremated. It is to be filled out in the presence of the deceased, or of the next of kin, or of the coroner or other person who has examined the body, or of the undertaker or other person who has been in attendance at the death. It is to be filled out in the presence of the deceased, or of the next of kin, or of the coroner or other person who has examined the body, or of the undertaker or other person who has been in attendance at the death.

823

CERTIFICATE OF DEATH

Reg. Dist. No.

00793

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				1. d. STREET ADDRESS <u>14610 Goodhope Road</u>			
3. NAME OF DECEASED (Type or print) <u>INFANT (Newborn)</u> First <u>CARROLL</u> Middle <u></u> Last <u></u>				4. DATE OF DEATH <u>JAN-28</u> Month <u>JAN</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/27/59</u>	
9. AGE (In years lost birthday) <u>2</u> yrs.		IF UNDER 1 YEAR <u>2</u> Months <u>45</u> Days		IF UNDER 24 HRS. <u>2</u> Hours <u>45</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Edward Carroll</u>				14. MOTHER'S MAIDEN NAME <u>Theresa L. Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>William Edward Carroll</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Failure</u> <u>774X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immaturity</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 28</u> , 19 <u>59</u> , to <u>Jan 28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 28</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas M. Wilson</u> M.D.				ADDRESS (Street, city or town, state) <u>8218 WILSON AVE</u> DATE SIGNED <u></u>			
PHYSICIAN'S NAME (Type) <u>THOMAS M. WILSON, M.D.</u>				BETHESDA 14, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2.2.59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. McGuire</u> ADDRESS <u>1820 9th St., N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carroll S. Knead</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

824

CERTIFICATE OF DEATH

Reg. Dist. No.

00794

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
f. STREET ADDRESS <u>Viers</u>		g. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First <u>Emily</u> Middle <u>Thomas</u> Last <u>Cashell</u>		4. DATE OF DEATH Month <u>January</u> Day <u>6</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10.24.1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Stenographer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Franklin Cashell</u>		14. MOTHER'S MAIDEN NAME <u>Emily Elizabeth Groomes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary insufficiency</u> (c) <u>Bronchopneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February</u> , 19 <u>58</u> , to <u>January 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>January 6</u> , 19 <u>59</u> , and that death occurred at <u>2:00 a.m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. A. Lanthorn</u> M.D.		ADDRESS (Street, city or town, state) <u>24 N. Summit Ave. Gaithersburg, Md.</u> DATE SIGNED <u>1/6/59</u>	
PHYSICIAN'S NAME (Type) <u>W. A. Lanthorn</u> M.D.		ADDRESS <u>Gaithersburg, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/9/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROCKVILLE CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ROCKVILLE, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pumphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>JAN 9 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

825

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pennsylvania</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>Three months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4709 Chestnut Street</u>		d. STREET ADDRESS <u>Second Street</u>	
3. NAME OF DECEASED (Type or print) First <u>BRIDGET</u> Middle <u>F</u> Last <u>CAWLEY</u>		4. DATE OF DEATH Month <u>1</u> Day <u>2</u> Year <u>19 59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10, 1875</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Fox</u>		14. MOTHER'S MAIDEN NAME <u>Bridget brane</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Dr. P. Bomer</u>		Address <u>4709 Chestnut St. Bethesda Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u> <u>years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>house</u> , 19 <u>58</u> , to <u>Jan 2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 2</u> , 19 <u>59</u> , and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert H. Boock</u>		ADDRESS (Street, city or town, state) <u>4630 Montgomery Ave.</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>		DATE SIGNED <u>1/2/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial-Transit 1-5-59</u>		<u>St. Thomas Cemetery</u>	<u>Archbald, Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>JAN 7 1959</u>		<u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH HOME		DATE OF DEATH OCT 10 1910	
NAME OF DECEASED ROBERT A. TUNNEY		SEX MALE	
AGE 35		COLOR WHITE	
OCCUPATION LABORER		MARITAL STATUS SINGLE	
PLACE OF BIRTH NEW YORK		DATE OF BIRTH SEP 10 1875	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. H. [Signature]		SIGNATURE OF REGISTRAR [Signature]	
CITY BALTIMORE		COUNTY BALTIMORE	
STATE MARYLAND		YEAR 1910	

This certificate is to be filled out by the physician or other person who has attended the deceased, or by the registrar of the health department, or by the coroner, or by the undertaker, or by the person who has taken charge of the funeral. It is to be filled out in duplicate, one copy to be retained by the health department, and the other copy to be retained by the coroner, or by the undertaker, or by the person who has taken charge of the funeral.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00796

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montg.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>217 Manor Circle</i>				d. STREET ADDRESS <i>217 Manor Circle</i>			
3. NAME OF DECEASED (Type or print) <i>FLOSSIE MAY CHRISTOPHER</i>				4. DATE OF DEATH <i>January 29 1959</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 5, 1879</i>	9. AGE (In years last birthday) <i>79</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maine</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Lincoln Cilley</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Brown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>214-10-2455</i>		17. INFORMANT <i>Mrs. G. V. Edwards, 217 Manor Circle, Takoma Park, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema, Congestive failure</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive heart disease</i> DUE TO (c) <i>20 years</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Acute viral gastro-enteritis</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Sept. 6, 1958</i> to <i>Jan. 29, 1959</i> , that I last saw the deceased alive on <i>Jan. 29, 1959</i> , and that death occurred at <i>9:30 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Eino Magi</i>				ADDRESS (Street, city or town, state) <i>918 Univ. Blvd. East, Silver Spring, Maryland</i>			
DATE SIGNED <i>1/29/59</i>							
PHYSICIAN'S NAME (Type) <i>EINO MAGI</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb. 2, 1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Riverview Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Dorchester, Maine</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur H. Harris, 234 Carroll St. NW</i>				ADDRESS		24a. REC'D BY REGISTRAR <i>DATE 2 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San & Hosp.</u>				d. STREET ADDRESS <u>17311-15th Pl.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Vilis</u> Middle <u>Gottfrids</u> Last <u>Cimermanis</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 24, 1891</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Latvia</u>			
11. BIRTHPLACE (State or foreign country) <u>Latvia</u>				12. CITIZEN OF WHAT COUNTRY? <u>Latvia</u>			
13. FATHER'S NAME <u>Heinrich Cimermanis</u>				14. MOTHER'S MAIDEN NAME <u>Emma Grintahl</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-48-5622</u>			
17. INFORMANT <u>Richard Cimermanis</u> Address <u>7311-15th Pl.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia BILATERAL</u> DUE TO <u>493X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SENILITY</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <u>MEGALOCOLON; CONGESTIVE HEART FAILURE</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1-10-</u> <u>1958</u> , to <u>1-19-</u> <u>1959</u> , that I last saw the deceased alive on <u>1-18-</u> <u>1959</u> , and that death occurred at <u>10:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8829 FLOWER AVE</u> DATE SIGNED <u>1-19-59</u>							
ACTUAL SIGNATURE <u>Samuel A. Hillman</u> M.D.				PHYSICIAN'S NAME (Type) <u>SAMUEL A. HILLMAN MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Washington, D. C.</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u> ADDRESS <u>Washington, D. C.</u>				24a. REC'D BY REGISTRAR <u>JAN 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 year</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9501 Montgomery Dr</u>			4. STREET ADDRESS <u>9501 Montgomery Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>William Stanley Clark</u>			4. DATE OF DEATH <u>Jan 27 1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-02</u>		9. AGE (in years last birthday) <u>56</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ins. Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>					
13. FATHER'S NAME <u>Emmitt R Clark</u>			14. MOTHER'S MAIDEN NAME <u>Edna Lavathan</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>Lucille Clark (wife)</u>		
17. INFORMANT <u>Stu 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage & Cerebral laceration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bullet wound Thru skull (Rt temple)</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>5 27 1-27 1959</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	
		20f. (City or town) <u>Bethesda</u> (County) <u>Monty</u> (State) <u>md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Brosnaut</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-27-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosnaut</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	
		22d. LOCATION (City, town, or county) <u>Rockville, Maryland</u>		(State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. JAN 28 1959 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

288

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED
Name: John J. Smith
Age: 45 Sex: M
Race: W Birth Date: 10-15-1890
Place of Birth: Worcester, Mass.
Usual Residence: 123 Main St., Boston
Cause of Death: Myocardial Infarction
Date of Death: 11-10-1935
Time of Death: 11:00 AM
Place of Death: Home
Signature of Medical Examiner: Dr. J. H. Jones
Signature of Coroner: Mr. A. B. Clark
Signature of Registrar: Mr. C. D. Evans

POSTMORTEM
Findings: Heart enlarged, coronary arteries atheromatous, lungs congested.
Signature of Pathologist: Dr. F. G. Miller

TO BE FILLED BY THE REGISTRAR
Date of Burial: 11-12-1935
Place of Burial: St. Mary's Cemetery, Boston
Signature of Registrar: Mr. C. D. Evans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G237 1-20-59 et

827

CERTIFICATE OF DEATH

00799

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 6 DAYS. 9 HR. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL d. STREET ADDRESS STAR ROUTE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle ALBERT Last COON, SR.				4. DATE OF DEATH Month JANUARY Day 10 Year 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 6, 1897	
9. AGE (In years last birthday) 61 1/2 yrs.		IF UNDER 1 YEAR Months 6 Days 12 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FILTRATION SHIFT ENGINEER				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME THOMAS COON				14. MOTHER'S MAIDEN NAME MARY MARIE DISNEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NON		16. SOCIAL SECURITY NO. HOSPITAL RECORDS		17. INFORMANT OLNEY, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BILATERAL BRONCHOPNEUMONIA 2 DAYS 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JANUARY 4, 19 59 , to JANUARY 10, 19 59 , that I lost saw the deceased alive on JANUARY 10, 19 59 , and that death occurred at 1:10 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) CLARKSVILLE, MARYLAND DATE SIGNED 1-11-59							
ACTUAL SIGNATURE C.S. WHITAKER				PHYSICIAN'S NAME (Type) C.S. WHITAKER, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 13, 1959		22c. NAME OF CEMETERY OR CREMATORY Emmanuel Cemetery		22d. LOCATION (City, town, or county) (State) Scaggsville Md	
23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Canalecon, Laurel, Md				24a. REG'D BY REGISTRAR JAN 16 59		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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828 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 5 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES EATON CREECY				4. DATE OF DEATH Month Day Year JANUARY 29 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/9/1887	
9. AGE (In years lost birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) F.C.D.A.				10b. KIND OF BUSINESS OR INDUSTRY COMMUNICATION DEPT.		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME EDWARD WILLSON CREECY				14. MOTHER'S MAIDEN NAME MARGUERITTE BROWNE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. VW # 1		17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/28 , 19 59 , to 1/29 , 19 59 , that I last saw the deceased alive on 1/28 , 19 59 , and that death occurred at 12:40A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE J. W. Bird, M. D. M.D. Sandy Spring 1/29/59 PHYSICIAN'S NAME (Type) J. W. BIRD, M. D. SANDY SPRING, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/2/59		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE WERNER E. PUMPHREY, INC. Raymond D. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR FEB 2 1959 DATE	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanks			

1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

829

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 5 hours			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2007 Wyoming Ave., N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Robert Steven CUMMINGS			4. DATE OF DEATH Month Day Year January 26 19 59		
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 26, 1959		9. AGE (In years lost birthday) yrs. 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) Bethesda, Maryland	
13. FATHER'S NAME David G. DAWSON			14. MOTHER'S MAIDEN NAME Joanne Anita CUMMINGS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (M) Joanne A. Cummings, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Washington	
21. I certify that I attended the deceased from January 26, 1959 , to January 26, 1959 , that I last saw the deceased alive on January 26, 1959 , and that death occurred at 9:40 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda 14, Maryland DATE SIGNED 1-27-59					
ACTUAL SIGNATURE Howard A. Pearson M.D. U. S. Naval Hospital, NMMC					
PHYSICIAN'S NAME (Type) H. A. PEARSON, LT, MC, USN Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-59		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
22d. LOCATION (City, town, or county) Washington		22e. LOCATION (City, town, or county) D.C.		22f. LOCATION (City, town, or county) D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home			24a. REC'D BY REGISTRAR FEB 2 '59		
24b. REGISTRAR'S SIGNATURE Arthur L. Kenna			24c. REGISTRAR'S SIGNATURE Arthur L. Kenna		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051201XV2

— 7 —

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Columbia</u> COUNTY <u>D.C.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>19da.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>D.C.</u> <u>472-3</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San & Hosp</u>			d. STREET ADDRESS <u>4722 Quaker St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Hugh Luther Cunningham</u>	First <u>Hugh</u> Middle <u>Luther</u> Last <u>Cunningham</u>	4. DATE OF DEATH <u>Jan 10 1959</u>		Month <u>Jan</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-21-36</u>	9. AGE (In years last birthday) <u>22 yrs.</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.C.</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.C.</u>		13. FATHER'S NAME <u>Lloyd Cunningham</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Quarrel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Hosp Record</u>		17. INFORMANT Address <u>Hosp Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE, ACUTE, CONGESTIVE</u> 916.3 DUE TO <u>LEFT PLEURITIS, PERICARDITIS AND EPICARDITIS, ACUTE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>THORACOTOMY, EMERGENCY, DUE TO CARDIAC</u> (c) <u>ARREST DURING SURGERY</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS +</u> <u>2 DAYS</u> <u>2 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BURNS, DEEP AND EXTENSIVE, SEVERE CEREBRAL EDEMA & GENERAL TOXEMIA</u> (DEC. 22, 1958)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Clutch caught spine while standing by a bonfire</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>8</u> a.m. <u>pm</u> <u>12-22</u> 1958	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Building</u>	20f. (City or town) <u>Silver Spring</u> (County) <u>Montg.</u> (State) <u>MD.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-11-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Columbia, South Carolina</u>	
22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Stewart</u>		ADDRESS <u>30 H Street, N.E.</u>		24a. REC'D BY REGISTRAR <u>JAN 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thorne</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 may be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE
DEPT.

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
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97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Virginia c. COUNTY Alexandria			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 50 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital				d. STREET ADDRESS 211 West Walnut Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Stephen DAVITT				4. DATE OF DEATH Month Day Year January 20 1959			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-26-05	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative Officer				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy Dept.		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Stephen DAVITT				14. MOTHER'S MAIDEN NAME Mary FALETTE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1924-1930				16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) bronchopneumonia 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pancoast Tumor of Lung, left DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH 10 days 6 months			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from December 1, 1958 , to January 20, 1959 , that I last saw the deceased alive on January 20, 1959 , and that death occurred at 10:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE M. W. Wood				ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC		DATE SIGNED 1-20-59	
PHYSICIAN'S NAME (Type) M. W. WOOD, LCDR MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment				22b. DATE THEREOF 1-22-59		22c. NAME OF CEMETERY OR CREMATORY UNKNOWN	
22d. LOCATION (City, town, or county) (State) Danville Pa.							
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home				24a. REC'D BY REGISTRAR DC		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	
24c. ADDRESS Deal Funeral Home, 4812 Ga. Ave, NW, Washington				24d. DATE JAN 22 '59			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the General Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

40304

WESTLAND STATE DEPARTMENT OF HEALTH - BATHING BEACH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

WESTLAND STATE DEPARTMENT OF HEALTH - BATHING BEACH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF EXAMINER	
10. SIGNATURE OF WITNESS		11. SIGNATURE OF JURY		12. SIGNATURE OF CORONER	
13. SIGNATURE OF MINISTER		14. SIGNATURE OF CHURCH		15. SIGNATURE OF FUNERAL HOME	
16. SIGNATURE OF BURIAL PLACE		17. SIGNATURE OF INTERMENT		18. SIGNATURE OF RECORDS	
19. SIGNATURE OF VITALS		20. SIGNATURE OF DEATH		21. SIGNATURE OF CERTIFICATE	
22. SIGNATURE OF DEATH		23. SIGNATURE OF DEATH		24. SIGNATURE OF DEATH	
25. SIGNATURE OF DEATH		26. SIGNATURE OF DEATH		27. SIGNATURE OF DEATH	
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100. SIGNATURE OF DEATH		101. SIGNATURE OF DEATH		102. SIGNATURE OF DEATH	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 27504 Ridge Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ethel Middle W. Last Day				4. DATE OF DEATH Month Jan. Day 14 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 22, 1876	
9. AGE (In years lost birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Damascus, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John R. Mount				14. MOTHER'S MAIDEN NAME Susan C. Molesworth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Frances W. Moxley, Damascus, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/21 , 19 43 , to 11/14 , 19 59 , that I last saw the deceased alive on 11/13 , 19 59 , and that death occurred at 6:00 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 11/15/59							
ACTUAL SIGNATURE James P. Kerr M.D.							
PHYSICIAN'S NAME (Type) Dr. James P. Kerr, M.D.				Damascus, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 16, 1959		22c. NAME OF CEMETERY OR CREMATORY Damascus		22d. LOCATION (City, town, or county) (State) Damascus, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Molesworth ADDRESS Damascus, Md.				24a. REC'D BY REGISTRAR DATE JAN 19 '59		24b. REGISTRAR'S SIGNATURE Arthur P. H...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Florida</u> b. COUNTY <u>WHITEHALL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tampa</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sharon Nursing Home</u>		d. STREET ADDRESS <u>3006 San Nicholas Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>(CORP) CARRIE C. Dayton</u>		4. DATE OF DEATH <u>January 23 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-6-69</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE (In years last birthday) <u>89</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Mount Hope N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Chapman</u>		14. MOTHER'S MAIDEN NAME <u>Myra Jane</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Marion D. Todd</u>		Address <u>Rt. 1 Box 52-C W.Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> , 19____, to <u>Jan 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 15</u> , 19 <u>57</u> , and that death occurred at <u>7:40</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>Lawrence J. Thomas M.D.</u> M.D. _____			
PHYSICIAN'S NAME (Type) <u>900 17th St N.W. WASH 6, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-24-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Beth Bury.</u>	22d. LOCATION (City, town, or county) (State) <u>New York New York</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. N. Chambers Co., Inc. 1400 - Chapin St.</u>		24a. REC'D BY REGISTRAR <u>JAN 26 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

834

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4820 Auburn Avenue				d. STREET ADDRESS 4820 Auburn Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last William Theodore Denell				4. DATE OF DEATH Month Day Year January 30, 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 18, 1898	
				9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 7 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) P Police - Retired				10b. KIND OF BUSINESS OR INDUSTRY Policeman		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William T. Denell				14. MOTHER'S MAIDEN NAME Claretta Barnes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Edna Nelson Denell - as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myocardial Infarction DUE TO (c) Arteriosclerotic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH Immediate			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus Pulmonary Infarction (old) Hemothorax				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from August , 19 56 , to January 30 , 19 59 , that I last saw the deceased alive on January 27 , 19 59 , and that death occurred at 1:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Suite 400, 8218 Wisconsin Ave. DATE SIGNED 1/30/59 ACTUAL SIGNATURE Edward S. Witowski, Jr. M.D. PHYSICIAN'S NAME (Type) EDWARD S. WITOWSKI, JR. M.D. BETHESDA 14, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 3, 1959		22c. NAME OF CEMETERY OR CREMATORY Potomac Methodist		22d. LOCATION (City, town, or county) (State) Potomac, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				24a. REC'D BY REGISTRAR FEB 2 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

835

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MONTGOMERY Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bethesda (Rural)			
3. NAME OF DECEASED (Type or print) First Middle Last Laura Francis DEWITT				4. DATE OF DEATH Month Day Year January 18 1959			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-7-99	
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph P. FRANCIS				14. MOTHER'S MAIDEN NAME Abigail GOULD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO.		17. INFORMANT Address (H) Charles K. DeWitt, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction of myocardium 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0							INTERVAL BETWEEN ONSET AND DEATH Immediate
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 18, 1959 to January 18, 1959 , that I last saw the deceased live on January 18, 1959 , and that death occurred at 8:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C. U. Shilling M.D. U. S. Naval Hospital 1-19-59							
ACTUAL SIGNATURE C. U. Shilling				PHYSICIAN'S NAME (Type) C. U. SHILLING, LT, MC, USN Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-22-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Jos. Gawler's & Sons				ADDRESS 1756 Penna. Ave		24a. REC'D BY REGISTRAR JAN 20 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kline							

Deceased had been patient at U.S. Naval Hospital from 12-29-57 to 1-30-58 and 3-23-58 to 5-29-58. Also being treated as out patient, last seen in clinic 8-15-58. Dr. Broschart, Mont. Co. Med. Examiner notified.

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

335

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

MD-02

<p>1. Name of deceased (Print or write full name) _____</p>	
<p>2. Sex (Print or write) _____</p>	
<p>3. Date of birth (Print or write) _____</p>	
<p>4. Place of birth (Print or write) _____</p>	
<p>5. Date of death (Print or write) _____</p>	
<p>6. Place of death (Print or write) _____</p>	
<p>7. Cause of death (Print or write) _____</p>	
<p>8. Signature of physician (Print or write) _____</p>	
<p>9. Signature of registrar (Print or write) _____</p>	
<p>10. Signature of informant (Print or write) _____</p>	
<p>11. Address of informant (Print or write) _____</p>	
<p>12. Date of filing (Print or write) _____</p>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hosp.</u>		d. STREET ADDRESS <u>10208 Georgia Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Melinda Frances Di Paolo</u>		4. DATE OF DEATH Month <u>1</u> - Day <u>6</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-12-90</u>
9. AGE (In years, last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR: Months <u>1</u> Days <u>6</u> Hours <u>1</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Charles Mancini</u>		14. MOTHER'S MAIDEN NAME <u>Mary Nicholas DelVecchio</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CARCINOMA, RIGHT LUNG</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 18</u> , 19 <u>58</u> , to <u>JAN 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JAN 6</u> , 19 <u>59</u> , and that death occurred at <u>4:50 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10620 GEORGIA AVE</u> DATE SIGNED <u>SILVER SPRING, MD.</u>			
ACTUAL SIGNATURE <u>Edward A. Beeman</u> M.D. <u>10620 GEORGIA AVE</u>			
PHYSICIAN'S NAME (Type) <u>EDWARD A. BEEMAN</u> <u>SILVER SPRING, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>1/10/59</u>	<u>GATE OF HEAVEN CEMETERY</u>	<u>MONTGOMERY COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

836

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>		d. STREET ADDRESS <u>Route #3</u>	
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>May</u> Last <u>Dorsey</u>		4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2.7.10</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Warner</u>		14. MOTHER'S MAIDEN NAME <u>Laura Matthews</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>217-22-4258</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Cervix</u> <u>171X</u> DUE TO (b) <u>Generalized pelvic Metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>December 31 19 58</u> , to <u>January 10, 19 59</u> , that I last saw the deceased alive on <u>January 10</u> , 19 <u>59</u> , and that death occurred at <u>2:43 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sandy Spring, Maryland</u> DATE SIGNED <u>1.10.59</u>			
ACTUAL SIGNATURE <u>JWB</u>		M.D. <u> </u>	
PHYSICIAN'S NAME (Type) <u>J. W. Bird, M. D.</u>		<u>Sandy Spring, Maryland</u> <u>1.10.59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 13, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Simpson Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Poplar Springs, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chin L. Moberneth</u>		ADDRESS <u>Damascus, Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
AGE		SEX	
RACE		RELIGION	
BIRTH DATE		BIRTH PLACE	
EDUCATION		OCCUPATION	
MARRIAGE DATE		MARRIAGE PLACE	
PREVIOUS DEATHS		PREVIOUS CAUSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>X</u> Gaithersburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS <u>103 Summitt Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Brexx</u> Middle <u>Ralph</u> Last <u>Allen</u> Drew				4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-29-59</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>&</u> Hours <u>21</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>							
13. FATHER'S NAME <u>Edgar William Drew</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Ann Wetherell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Barbara Ann Drew</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>762.0</u> IMMEDIATE CAUSE (a) <u>Atch Tash</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Jan. 29</u> , 19 <u>59</u> , to <u>Jan. 31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan. 31</u> , 19 <u>59</u> , and that death occurred at <u>Jan. 31</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Jack Schumacher</u> M.D. <u>Gaithersburg, Md. 1-31-59</u> PHYSICIAN'S NAME (Type) <u>Jack Schumacher, M.D.</u> <u>Gaithersburg, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Feb. 2 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran</u>	
22d. LOCATION (City, town, or county) <u>Redland</u>				(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W Barber</u> ADDRESS <u>Laytonsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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2073181XV5

CERTIFICATE OF DEATH

653

JAMES BOND
JAMES BOND
JAMES BOND

Attest

1897

838 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS NURSING HOME				d. STREET ADDRESS 608 A Street, S.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CARRIE Middle W. Last ECKAM				4. DATE OF DEATH Month JAN. Day 18 Year 19 59			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/6/67	
9. AGE (In years lost birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) NEW YORK STATE	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CLARENCE WICKHAM				14. MOTHER'S MAIDEN NAME MARIETTA PRATT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT Mrs. Broheim Ebbess, 12,825 Baker Drive Silver Spring, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 3 wks 10 yrs 20 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept 8, 1958 , to Jan 18, 1959 , that I last saw the deceased alive on Jan 18, 1959 , and that death occurred at 11:15 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE [Signature] M.D. 7852 16 NW Wash 12 1/18/59							
PHYSICIAN'S NAME (Type) 16 F Kreuzburg							
22a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT		22b. DATE THEREOF 1/20/59		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN MAUSOLEUM		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC. Raymond A. Ziska				24a. REC'D BY REGISTRAR JAN 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

00813

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 32 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Norfolk c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) South Norfolk d. STREET ADDRESS 617 B Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Elsie Lee Eckleberry		4. DATE OF DEATH Month Day Year January 2, 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1900 9. AGE (In years last birthday) 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin Winn		14. MOTHER'S MAIDEN NAME Elizabeth (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 1, 19 58 , to January 2, 19 59 , that I lost saw the deceased alive on January 2, 19 59 , and that death occurred at 6:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur T. Teplitzky		ADDRESS (Street, city or town, state) The Clinical Center The National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Arthur T. Teplitzky, M.D.		DATE SIGNED 1-2-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit	22b. DATE THEREOF 1/2/59	22c. NAME OF CEMETERY OR CREMATORY Riverside	22d. LOCATION (City, town, or county) (State) Norfolk, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE JAN 5 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1930

See Question

Signature

Signature

Joseph Wolfson

37 1/2

The Clinical Cancer Research Institute, Inc.

Philadelphia

Illinois

June 30, 1930

Waco

Joseph Wolfson

Male

Residence

Philadelphia (Illinois)

Residence

The Clinical Cancer Research Institute, Inc.

Illinois

Illinois

Occupation

Research Institute

Signature

Signature

December 1, 1930

30

Signature

The Clinical Cancer

The National Cancer Institute

Baltimore, Maryland

Signature

Signature

Signature

Signature

840

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5921 Beech Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Karl First Valentine Middle Eiker Last Jr				4. DATE OF DEATH Jan Month 21 Day 19 Year 59			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1921		9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months 8 Days 19 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lithographer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Karl V. Eiker, Sr.				14. MOTHER'S MAIDEN NAME Martha King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW 2		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Winifred A. Eiker-wife-same as 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple cerebral hemorrhages 467.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) congenital telangiectasia DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 6 yrs 37 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 21, 1959 to Jan 21, 1959 , that I last saw the deceased alive on Jan 21, 1959 , and that death occurred at 8 A M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7852 16th St. N. W. Washington DC DATE SIGNED 1/21/59							
ACTUAL SIGNATURE H. F. Kreuzburg M.D.							
PHYSICIAN'S NAME (Type) H. F. Kreuzburg				7852-16th St. N. W. Washington DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/59		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JAN 23 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

765

CERTIFICATE OF DEATH

Reg. Dist. No.

00815

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Spotsylvania</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fredricksburg</u> 83x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hospital</u>				d. STREET ADDRESS <u>812 Woodon</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie</u> <u>Geraldine</u> <u>Ellis</u>				4. DATE OF DEATH Month Day Year <u>1</u> <u>21</u> <u>1959</u>			
5. SEX <u>fe</u>	6. COLOR OR RACE <u>wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/26/84</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswn</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George William Nicholson</u>				14. MOTHER'S MAIDEN NAME <u>Joanna Lewis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>PH's hosp. Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x</u> <u>Anuria - Chronic Nephritis</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Diabetic Coma</u> DUE TO (c) <u>1 day</u> <u>1 day</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1-11-</u> , 19 <u>59</u> , to <u>1-21-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-21-</u> , 19 <u>59</u> , and that death occurred at <u>9:20 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u>				ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u> DATE SIGNED <u>1/21/59</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Hare, MD.</u>				<u>Takoma Park, Md.</u> <u>1/21/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>1/22/59</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Fredricksburg, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Harely</u> ADDRESS <u>809 King St. & B. Va.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hare</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

766

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Green belt</i> 1623.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash Sant Hosp.</i>				d. STREET ADDRESS <i>116 Northway</i>			
3. NAME OF DECEASED (Type or print) First <i>Ella</i> Middle <i>Louise</i> Last <i>Engelhardt</i>				4. DATE OF DEATH Month <i>January</i> Day <i>19</i> Year <i>1959</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-11-94</i>	9. AGE (In years last birthday) <i>64</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary to husband</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Naturopath</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Charles Ponger</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-52-8477</i>		17. INFORMANT <i>Husband - by chart</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>171X</i> DUE TO <i>Insanitation</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Beremonia glervix</i> DUE TO (c) <i>One year</i>						INTERVAL BETWEEN ONSET AND DEATH <i>One year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>10-16-</i> 19 <i>58</i> , to <i>1-19-</i> 19 <i>59</i> , that I lost saw the deceased olive on <i>1-19</i> 19 <i>59</i> , and that death occurred at <i>8:20 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Robert A. Hare</i> M.D.				ADDRESS (Street, city or town, state) <i>Takoma Park Md.</i>		DATE SIGNED <i>1/19/59</i>	
PHYSICIAN'S NAME (Type) <i>Robert A. Hare MD.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>1/20/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Crematory</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Georges County, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>S.H. Harris Co</i>				ADDRESS <i>2901-14th St. N.W.</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 20 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

841

CERTIFICATE OF DEATH

00817

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4706 Jamestown Road</u>		d. STREET ADDRESS <u>4706 Jamestown Rd Bethesda</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Frances</u> Last <u>Evans</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 17, 1958</u>
9. AGE (In years last birthday) <u>XXXXXXXX</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William H. Evans</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Hollyfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Dr. Tilley's Office</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5272</u> DUE TO <u>Asphyxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Respiratory Infection</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>12-24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October 1958</u> to <u>1-19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-19</u> , 19 <u>59</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.M. Tilley, Jr.</u>		DATE SIGNED <u>4701-Mass. Ave. NW 1-20-59</u>	
PHYSICIAN'S NAME (Type) <u>R. M. Tilley, Jr.</u>		<u>Wash. 16, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>	22b. DATE THEREOF <u>1/21/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Frankfort</u>	22d. LOCATION (City, town, or county) (State) <u>Frankfort, Kentucky</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 23 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>	

CERTIFICATE OF DEATH

Name of Deceased		JAMES H. HENRY	
Sex		Male	
Age		38	
Date of Birth		Oct. 15, 1908	
Place of Birth		St. Louis, Mo.	
Cause of Death		Influenza	
Date of Death		Oct. 17, 1918	
Place of Death		St. Louis, Mo.	
Occupation		None	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Signature of Coroner		[Signature]	
Signature of Burial Officer		[Signature]	
Signature of Minister		[Signature]	
Signature of Undertaker		[Signature]	
Signature of Witness		[Signature]	
Signature of Second Witness		[Signature]	
Signature of Third Witness		[Signature]	
Signature of Fourth Witness		[Signature]	
Signature of Fifth Witness		[Signature]	
Signature of Sixth Witness		[Signature]	
Signature of Seventh Witness		[Signature]	
Signature of Eighth Witness		[Signature]	
Signature of Ninth Witness		[Signature]	
Signature of Tenth Witness		[Signature]	
Signature of Eleventh Witness		[Signature]	
Signature of Twelfth Witness		[Signature]	
Signature of Thirteenth Witness		[Signature]	
Signature of Fourteenth Witness		[Signature]	
Signature of Fifteenth Witness		[Signature]	
Signature of Sixteenth Witness		[Signature]	
Signature of Seventeenth Witness		[Signature]	
Signature of Eighteenth Witness		[Signature]	
Signature of Nineteenth Witness		[Signature]	
Signature of Twentieth Witness		[Signature]	
Signature of Twenty-first Witness		[Signature]	
Signature of Twenty-second Witness		[Signature]	
Signature of Twenty-third Witness		[Signature]	
Signature of Twenty-fourth Witness		[Signature]	
Signature of Twenty-fifth Witness		[Signature]	
Signature of Twenty-sixth Witness		[Signature]	
Signature of Twenty-seventh Witness		[Signature]	
Signature of Twenty-eighth Witness		[Signature]	
Signature of Twenty-ninth Witness		[Signature]	
Signature of Thirtieth Witness		[Signature]	

MISSOURI STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00818

842

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>12 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8809 BRADFORD ROAD.</u>				d. STREET ADDRESS <u>18809 BRADFORD ROAD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>EDWARD</u> Last <u>FANHY JR</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8, 1904</u>	9. AGE (In years last birthday) <u>54 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Heating Engineer.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Heating</u>		11. BIRTHPLACE (State or foreign country) <u>York, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>THOMAS E. FANHY</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE REAGAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>181-07-5142</u>		17. INFORMANT <u>JACK FANHY</u> Address <u>4709 BOILING BROOK PKWY ROCKVILLE, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Coronary artery Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> <u>24 HRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 23 1957</u> , to <u>JAN. 18 1959</u> , that I last saw the deceased alive on <u>Jan. 18 1959</u> , and that death occurred at <u>10:29 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>James A. Roberts</u> M.D. <u>8107 GEORGIA AVENUE</u> <u>1/15/59</u> PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u> <u>SILVER SPRING, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WALTER E. PUMPHREY, INC.</u> <u>Raymond W. Ziska</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

823

DATE OF DEATH		PLACE OF DEATH	
JAN 10 1917		BALTIMORE	
DECEASED'S NAME		SEX	
JOHN J. JONES		MALE	
AGE		RACE	
45		WHITE	
BIRTH DATE		BIRTH PLACE	
JAN 10 1872		BALTIMORE	
OCCUPATION		CAUSE OF DEATH	
LABORER		HEART DISEASE	
MANNER OF DEATH		MEDICAL ATTENDANT	
NATURAL		DR. J. J. JONES	
SIGNATURE OF DECEASED		SIGNATURE OF MEDICAL ATTENDANT	
		J. J. JONES	
SIGNATURE OF REGISTRAR		OFFICIAL USE	
J. J. JONES		BALTIMORE	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. STREET ADDRESS 5613 Belmont Ave.	
3. NAME OF DECEASED (Type or print) First Effie Middle Brooke Last Falck		4. DATE OF DEATH Month Jan Day 29 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1887
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Brooke		14. MOTHER'S MAIDEN NAME Mary L. Arnold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. J. Stanley Falck	
17. INFORMANT 5613 Belmont Ave. Chevy Chase, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF CECUM DUE TO 153.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastases to Regional Lymph Nodes Liver and Lungs. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Atherosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 13, 1958 , to January 28, 1959 , that I last saw the deceased alive on January 28, 1958 , and that death occurred at 7:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Michael M. Haly		M.D. WASHINGTON CLINIC, WASHINGTON, D.C.	
PHYSICIAN'S NAME (Type)		DATE SIGNED 1/29/59	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 1/31/59	22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cmn.	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Chevy Chase Funeral Home		24a. REC'D BY REGISTRAR WASHINGTON, D.C.	24b. REGISTRAR'S SIGNATURE Arthur S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 9 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY 47x-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, District of Columbia d. STREET ADDRESS 3011 Clinton Street, N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Sadie Reeves Fequa			4. DATE OF DEATH Month Day Year January 11, 19 59		
5. SEX Female	6. COLOR OR RACE Negroe	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 17, 1912		9. AGE (In years last birthday) 46 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Bezail White		
14. MOTHER'S MAIDEN NAME Virginia Wards			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 578-44-0784			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphoblastic, lymphosarcoma 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3011 Clinton Street, N.E.	
20f. (City or town) Bethesda		20g. (County) Montgomery		20h. (State) District of Columbia	
21. I certify that I attended the deceased from January 2, 19 59 , to January 11, 19 59 , that I last saw the deceased alive on January 11, 19 59 , and that death occurred at 3:45a M. from the causes and on the date stated above.					
ACTUAL SIGNATURE James M. Marsh		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 1/11/59	
PHYSICIAN'S NAME (Type) JAMES M. MARSH, M.D.		NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/15/59		22c. NAME OF CEMETERY OR CREMATORY New Hope Cemetery	
22d. LOCATION (City, town, or county) New Hope, Virginia		22e. (State) Virginia		23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Marsh	
23a. ADDRESS 30 H Street, N.E.		23b. REC'D BY REGISTRAR DATE JAN 13 '59		23c. REGISTRAR'S SIGNATURE Arthur S. Marsh	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

IN THE STATE OF NEW YORK

FILE NO.

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF AGENT

NAME OF INSPECTOR

NAME OF SUPERVISOR

NAME OF CHIEF

NAME OF DEPUTY

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF AGENT

NAME OF INSPECTOR

NAME OF SUPERVISOR

NAME OF CHIEF

NAME OF DEPUTY

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF AGENT

NAME OF INSPECTOR

NAME OF SUPERVISOR

NAME OF CHIEF

NAME OF DEPUTY

NAME OF CLERK

NAME OF ASSISTANT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00821

845

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>2 1/2 yrs.</i> x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>571 University Drive</i>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Luella</i> First Middle Last <i>Finnell</i>		4. DATE OF DEATH <i>January</i> Month Day Year <i>18 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-1-1872</i>
9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>George Connor Pulliam</i>		14. MOTHER'S MAIDEN NAME <i>Luzetta Pulliam</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)	
17. INFORMANT <i>Mrs Ruth Boetzman</i>		Address <i>10601-Kinlock Rd. S.S.Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral Hemorrhage</i> <i>331x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>7 hrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1-12</i> , 19 <i>59</i> , to <i>1-18</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>1-18</i> , 19 <i>59</i> , and that death occurred at <i>645 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>S. P. Porton</i>		ADDRESS (Street, city or town, state) <i>300-Hamilton St. N.W. Washington D.C.</i>	
PHYSICIAN'S NAME (Type) <i>S. P. PORTON</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-21-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Massanutten</i>		22d. LOCATION (City, town, or county) (State) <i>Woodstock Va</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. L. Dellinger</i>		ADDRESS <i>Woodstock, Va.</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	
DATE <i>JAN 20 '59</i>			

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>minutes</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Cecile</u> Middle <u>A</u> Last <u>Fitzpatrick</u>				4. DATE OF DEATH Month <u>1</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 30 1894</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Kelly</u>				14. MOTHER'S MAIDEN NAME <u>Brooklyn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Frances Hewitt - Douglas - Sam</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> <u>416 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic Heart Disease (myxomatous)</u> DUE TO (c) <u>1840cm.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15-30 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>January 8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>January 8</u> , 19 <u>59</u> , and that death occurred at <u>6:02</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.B. Wardrop MD</u>				DATE SIGNED <u>837 Bonifant St. Silver Spring, Md. 1/8/59</u>			
PHYSICIAN'S NAME (Type) <u>W.B. WARDROP, MD</u>				ADDRESS (Street, city or town, state) <u>837 Bonifant St. Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Warren Taltavall</u>				ADDRESS <u>3603-14th St N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 12 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kinn</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Wash. D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

00823

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville, Md.</u>		c. LENGTH OF STAY IN 1b <u>15 1/2 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor Sanitarium</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u> <u>47X-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>D.</u> Last <u>Foster</u>		d. STREET ADDRESS <u>4411 Albemarle St., N.W.</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/11/12</u>	
9. AGE (In years lost birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u>40</u> Days <u>29</u> Hours <u></u> Min. <u></u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u>	
13. FATHER'S NAME <u>Bernard J. De Wit</u>		14. MOTHER'S MAIDEN NAME <u>Ethel A. De Wit</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Sarah F. Fawcett</u>		Address <u>4411 Albemarle St., Wash., D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BILATERAL BRONCHIAL PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERALIZED ARTERIOSCLEROSIS SENILITY</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>55</u> , to <u>JAN 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JAN 10</u> , 19 <u>59</u> , and that death occurred at <u>9:45 P.M.</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>1-10-59</u> DATE SIGNED			
ACTUAL SIGNATURE <u>P.P. Andrews M.D.</u> M.D. <u>4201 Kensington ST N.W. Washington 16 D.C.</u>			
PHYSICIAN'S NAME (Type) <u>P.P. ANDREWS M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-12-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda 14, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE</u> <u>1 4 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>			

792
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>1 week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5720 Crawford Drive</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
				f. STREET ADDRESS <u>5720 Crawford Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Karen Lee</u> Middle <u>Frick</u> Last <u>Frick</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 9 1959</u>	
9. AGE (In years lost birthday) yrs. <u>11</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min. <u>11</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Gerald P. Frick</u>		14. MOTHER'S MAIDEN NAME <u>Lois L. Whiteman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Gerald P. Frick, 5720 Drawford Drive, Rockville, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Longestive heart failure</u> <u>754.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congenital heart disease (Hypoplasia of the aorta)</u> DUE TO (c) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 15</u> 19 <u>59</u> to <u>Jan 20</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 20</u> 19 <u>59</u> , and that death occurred at <u>9:35</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Raymond Bradshaw</u>				ADDRESS (Street, city or town, state) <u>345 University Boulevard, West 1/20/59</u>			
PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u>				DATE SIGNED <u>Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/22/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. FUMPHREY, INC.</u> <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 22 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

847

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) 6206 Singleton Place		d. STREET ADDRESS 6206 Singleton Place	
3. NAME OF DECEASED (Type or print) First AGNES Middle V. Last FRISBIE		4. DATE OF DEATH Month January Day 22 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1872
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 7 Days 28 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Barnes		14. MOTHER'S MAIDEN NAME Rose Queen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Kenneth W Frisbie		Address 7803 Stratford Rd. Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis, severe DUE TO (c) Arteriosclerosis, generalised		INTERVAL BETWEEN ONSET AND DEATH 15 Min. 10 yrs + 10 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1946 , to Jan 22 , 1959, that I last saw the deceased alive on Jan 13 , 1959, and that death occurred at 10:15 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stewart Clapp		M.D. 3921 Ingomar St. DATE SIGNED 1-22-59	
PHYSICIAN'S NAME (Type) Stewart Clapp		Wash 15 DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/26/59	22c. NAME OF CEMETERY OR CREMATORY Potomac Church	22d. LOCATION (City, town, or county) (State) Potomac, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE JAN 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

Coroner Notified & waived jurisdiction

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2839

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00826

848

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth H. Garrison</u>				4. DATE OF DEATH Month Day Year <u>Jan. 18 19 59</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 25 18 79</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John G. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Burrows</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Karl A. Voigt</u> Address <u>5214 Tilden Rd. Decatur Heights, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemiplegia, left, severe</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension, severe</u> DUE TO (c) <u>Arteriosclerosis, generalised</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>10 yrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 17</u> , 19 <u>59</u> , to <u>Jan 18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 17</u> , 19 <u>59</u> , and that death occurred at <u>2:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3921 Ingomar St. Wash. D.C.</u> DATE SIGNED <u>1-18-59</u>							
ACTUAL SIGNATURE <u>Stewart Clapp</u>				M.D. <u>3921 Ingomar St. Wash. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/20/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospers Hill Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cheng Chase Funeral Home</u> ADDRESS <u>5103 9th St NW</u>				24a. REC'D BY REGISTRAR <u>Charles E. Harris</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Harris</u>	
				DATE <u>JAN 21 1959</u>			

CERTIFICATE OF DEATH

842

Birth Date: Jan. 1900

1. NAME OF DECEASED JOHN J. BROWN		2. SEX Male		3. AGE 45	
4. DATE OF DEATH Jan. 1940		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Coronary Thrombosis		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md.	
10. OCCUPATION Clerk		11. MARITAL STATUS Married		12. EDUCATION High School	
13. PREVIOUS ILLNESS None		14. MEDICAL HISTORY None		15. SURVIVAL OF OTHERS None	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF NEXT OF KIN John J. Brown		18. SIGNATURE OF PHYSICIAN Dr. J. J. Brown	
19. SIGNATURE OF REGISTRAR J. J. Brown		20. SIGNATURE OF CLERK J. J. Brown		21. SIGNATURE OF WITNESS J. J. Brown	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00827

849

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>19 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				f. STREET ADDRESS <u>19209 Quintana DR</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>C</u> Last <u>Gibb</u>				4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 27 1910</u>	
9. AGE (In years lost birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u> Hours <u>16</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Analyst</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>China</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John M. Gibb</u>				14. MOTHER'S MAIDEN NAME <u>Candler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Frances H Gibb</u> Address <u>Wife - Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart Failure</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>LESS THAN 18 days</u> <u>18 days</u> <u>LESS THAN 18 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec 26</u> , 19 <u>58</u> , to <u>Jan 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>January 13</u> , 19 <u>59</u> , and that death occurred at <u>8:50 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8016 Old Georgetown Rd. Bethesda, Md.</u> DATE SIGNED <u>1/13/59</u>							
ACTUAL SIGNATURE <u>Habeeb Bacchus</u>				M.D. <u>8016 Old Georgetown Rd. Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>HABEEB BACCHUS</u>				8016 Old Georgetown Rd., Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1-15-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY,</u> ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

CERTIFICATE OF DEATH

242

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		TIME OF BIRTH [Illegible]	
PLACE OF DEATH [Illegible]		DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF CLERK [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF JUDGE [Illegible]	

This is to certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the [Illegible] day of [Illegible], 19[Illegible].
 [Illegible]
 [Illegible]

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00828

Reg. Dist. No. 215

850

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Alexandria</u> Reston	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>30 Minutes</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u> 83x-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Hospital</u>		d. STREET ADDRESS <u>506 North Jordan Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Scott Allan Glickman</u>		4. DATE OF DEATH Month Day Year <u>1 14 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1 Sept 1958</u>
9. AGE (In years last birthday) <u>4mo 20</u>		IF UNDER 1 YEAR Months Days <u>4 14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arnold Lawrence Glickman</u>		14. MOTHER'S MAIDEN NAME <u>Arlynn Bethe Welber</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Arnold L. Glickman, 506 N Jordan St. Alex, Va</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> DUE TO <u>Fracture, simple, comminuted, depressed, traumatic, stellate, left parietal bone with extension to right, parietal bone and right and left temporal bones.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u>parietal bone and right and left temporal bones.</u> (c) <u>Apr. 2 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Child was carried by father who tripped and fell.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Child was carried by father who tripped and fell.</u>	
20c. TIME OF INJURY Month, Day, Year <u>9:45 p.m. Jan, 14 1959</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Alexandria Alexandria Va.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-18-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wellwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pinelawn, Long Island, N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Danzanski Funeral Home, 3501 14th St., NW, Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>JAN 19 59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9, Film G-238 2/18/59, cac.

00829

CERTIFICATE OF DEATH

851

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 34 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Fort Pierce 48 A-3 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last William Frederick Goffred			4. DATE OF DEATH Month Day Year January 25, 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 26, 1904		9. AGE (In years last birthday) 54 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Thomas Goffred		
14. MOTHER'S MAIDEN NAME Mina Suppe			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 152-03-3055			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute adrenal hemorrhage 274X -DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) acute myelogenous leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 mos. 4 mos.					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 22, 1958 , to January 25, 1959 , that I last saw the deceased alive on January 25, 1959 , and that death occurred at 3:05 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE James M. Marsh		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 1-26-59	
PHYSICIAN'S NAME (Type) James M. Marsh, M. D.		The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 1-27-59		22b. DATE THEREOF 1-27-59		22c. NAME OF CEMETERY OR CREMATORY Ft. Pierce	
22d. LOCATION (City, town, or county) (State) Lucie County, Florida		23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Md.		24a. REC'D BY REGISTRAR DATE JAN 29 1959	
24b. REGISTRAR'S SIGNATURE Arthur S. Marsh					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

852

CERTIFICATE OF DEATH

00830

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 90 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McLean d. STREET ADDRESS Box 32-H LaSalle Avenue, Route #5 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Bertha Middle Jane Last Gooding		4. DATE OF DEATH Month January Day 20, Year 1959				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 22, 1886	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 83 Days x Hours 3	IF UNDER 24 HRS. Hours 3 Min. 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas McCue			14. MOTHER'S MAIDEN NAME Elizabeth Neel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 234-09-4768D		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mycosis Fungoides with Lymphomatous Infiltrates 205x DUE TO in Skin, Liver, Kidneys, and Lymph Nodes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Years						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 22, 1958 , to January 20, 1959 , that I last saw the deceased alive on January 20, 1959 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1-21-59 ACTUAL SIGNATURE Leonard Garren M.D. NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland PHYSICIAN'S NAME (Type) Leonard Garren, M. D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Trans.		22b. DATE THEREOF 1/26/59		22c. NAME OF CEMETERY OR CREMATORY Benedum Cemetery		22d. LOCATION (City, town, or county) (State) Bridgeport, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE JAN 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE, MD.	
MARRIAGE		DATE		PLACE		NAME		DATE		PLACE	
MARRIED		1905		BALTIMORE		JAMES H. HARRIS		1905		BALTIMORE	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		DATE		PLACE	
HIGH SCHOOL		BALTIMORE		BALTIMORE		BALTIMORE		1905		BALTIMORE	
OCCUPATION		DATE		PLACE		NAME		DATE		PLACE	
BALTIMORE		1905		BALTIMORE		BALTIMORE		1905		BALTIMORE	
CAUSE OF DEATH		DATE		PLACE		NAME		DATE		PLACE	
BALTIMORE		1905		BALTIMORE		BALTIMORE		1905		BALTIMORE	
MANNER OF DEATH		DATE		PLACE		NAME		DATE		PLACE	
BALTIMORE		1905		BALTIMORE		BALTIMORE		1905		BALTIMORE	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME		DATE		PLACE	
BALTIMORE		1905		BALTIMORE		BALTIMORE		1905		BALTIMORE	
SIGNATURE OF REGISTRAR		DATE		PLACE		NAME		DATE		PLACE	
BALTIMORE		1905		BALTIMORE		BALTIMORE		1905		BALTIMORE	

853

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Washington d. STREET ADDRESS 1701 16th Street, N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Raymond (none) GOODMAN			4. DATE OF DEATH Month Day Year January 10 1959				
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-94	9. AGE (In years last birthday) yrs. 64	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) Washington, D. C.			
13. FATHER'S NAME Henry GOODMAN			14. MOTHER'S MAIDEN NAME Jennie NORDLINGER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO.		17. INFORMANT Official Navy Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CONS Cyanosis DUE TO (c) Diabetes mellitus, ASHDE Decomensation					INTERVAL BETWEEN ONSET AND DEATH 48 hours 10 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from January 7, 1959 , to January 10, 1959 , that I last saw the deceased alive on January 10, 1959 , and that death occurred at 4:00 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE C. U. Shilling		M.D. U. S. Naval Hospital, NNMC		DATE SIGNED 1-10-59			
PHYSICIAN'S NAME (Type) C. U. SHILLING, LT, MC, USN		Bethesda 14, Maryland					
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-13-59	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) Arlington	(State) Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Jos. Gawler's & Sons, 1756 Penna. Ave., NW, Wash. DC		24a. REC'D BY REGISTRAR JAN 13 '59	24b. REGISTRAR'S SIGNATURE Arthur E. House				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased (Print name and surname)		2. Sex		3. Age		4. Date of birth	
5. Date of death		6. Time of death		7. Place of death		8. Cause of death	
9. Signature of attending physician		10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of health officer		18. Signature of coroner		19. Signature of justice of the peace		20. Signature of other official	
21. Signature of other official		22. Signature of other official		23. Signature of other official		24. Signature of other official	
25. Signature of other official		26. Signature of other official		27. Signature of other official		28. Signature of other official	
29. Signature of other official		30. Signature of other official		31. Signature of other official		32. Signature of other official	
33. Signature of other official		34. Signature of other official		35. Signature of other official		36. Signature of other official	
37. Signature of other official		38. Signature of other official		39. Signature of other official		40. Signature of other official	
41. Signature of other official		42. Signature of other official		43. Signature of other official		44. Signature of other official	
45. Signature of other official		46. Signature of other official		47. Signature of other official		48. Signature of other official	
49. Signature of other official		50. Signature of other official		51. Signature of other official		52. Signature of other official	
53. Signature of other official		54. Signature of other official		55. Signature of other official		56. Signature of other official	
57. Signature of other official		58. Signature of other official		59. Signature of other official		60. Signature of other official	
61. Signature of other official		62. Signature of other official		63. Signature of other official		64. Signature of other official	
65. Signature of other official		66. Signature of other official		67. Signature of other official		68. Signature of other official	
69. Signature of other official		70. Signature of other official		71. Signature of other official		72. Signature of other official	
73. Signature of other official		74. Signature of other official		75. Signature of other official		76. Signature of other official	
77. Signature of other official		78. Signature of other official		79. Signature of other official		80. Signature of other official	
81. Signature of other official		82. Signature of other official		83. Signature of other official		84. Signature of other official	
85. Signature of other official		86. Signature of other official		87. Signature of other official		88. Signature of other official	
89. Signature of other official		90. Signature of other official		91. Signature of other official		92. Signature of other official	
93. Signature of other official		94. Signature of other official		95. Signature of other official		96. Signature of other official	
97. Signature of other official		98. Signature of other official		99. Signature of other official		100. Signature of other official	

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 1 1/2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 613 McNEILL ROAD				d. STREET ADDRESS 1 613 McNEILL ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HARRY DELAFIELD GRIMES				4. DATE OF DEATH Month Day Year JAN. 16 19 59			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/28/79		9. AGE (In years last birthday) yrs. 79	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY DRY GOODS		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE GRIMES				14. MOTHER'S MAIDEN NAME ANNIE JONES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-05-7350		17. INFORMANT Address Mrs. James W. Vandegrift, 613 McNeill Road Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 15</u> , 19 <u>59</u> , to <u>Jan. 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan. 15</u> , 19 <u>59</u> , and that death occurred at <u>5:30 a.m.</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Lewis A. Klein M.D. <u>1319 Highland Dr. Silver Spring, Md.</u> LEWIS A. KLEIN <u>Jan 16 '59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		22b. DATE THEREOF 1/16/59		22c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. <u>Raymond A. Gikas</u>		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE JAN 19 '59		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

VS A15 (4)
15M 10/57

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

855

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>6 mo</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1200 Tanby Rd</u>			d. STREET ADDRESS <u>1200 Tanby Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Walter Charles Hagerton</u>			4. DATE OF DEATH Month <u>1</u> Day <u>4</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-2-97</u>		9. AGE (in years last birthday) <u>61</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>electrical eng.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Navy Bureau Yards & Docks</u>		11. BIRTHPLACE (State or foreign country) <u>Mass</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>					
13. FATHER'S NAME <u>John Hagerton</u>			14. MOTHER'S MAIDEN NAME <u>unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES <u>WW #1</u>		16. SOCIAL SECURITY NO. <u>031-07-7821</u>		17. INFORMANT <u>Jane Ryan (daughter)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>451X</u> DUE TO <u>Ruptured aortic aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous heart disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschek</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschek</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>1-4-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/7/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 7 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Carlton S. House</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00834

856

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 15 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 619 GREENBRIAR DRIVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARY VERONICA HALL				4. DATE OF DEATH Month Day Year JANUARY 22 19 59			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 25, 1887		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CO-OWNER				10b. KIND OF BUSINESS OR INDUSTRY INFANT'S CLOTHING STORE		11. BIRTHPLACE (State or foreign country) ENGLAND	
13. FATHER'S NAME THOMAS J. HALL				14. MOTHER'S MAIDEN NAME CATHERINE M. T. LALLY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MISS ELLEN E. HALL, 619 GREENBRIAR DRIVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO Myo Cardial Degeneration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arterio-Sclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 days 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov 10, 1954 , to Jan 22, 1959 , that I last saw the deceased alive on Jan 21, 1959 , and that death occurred at 12:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Merrill M. Cross M.D.				ADDRESS (Street, city or town, state) 8248 Georgia Ave Silver Spring, Md		DATE SIGNED 1/22/59	
PHYSICIAN'S NAME (Type) MERRILL M. CROSS							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 26, 1959		22c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY		22d. LOCATION (City, town, or county) (State) VINELAND, NEW JERSEY	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziaka				ADDRESS SILVER SPRING, MD		24a. REC'D BY REGISTRAR Jan 26 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

262119

857

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Coatthensburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>11</u>			
3. NAME OF DECEASED (Type or print) First <u>Rodger</u> Middle <u>Murry</u> Last <u>Hollman</u>				4. DATE OF DEATH Month <u>1</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/5/193</u>	9. AGE (In years last birthday) <u>65</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>messenger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Labor</u>		11. BIRTHPLACE (State or foreign country) <u>Poolesville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Henry Hollman</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-03-122</u>		17. INFORMANT <u>Marion Hollman, Coatthensburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 451X DUE TO <u>Dissecting aortic aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture of aortic aneurysm</u> (c) <u>Rupture of aortic aneurysm</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1-1</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1-17-59</u> 19... to <u>1-18-59</u> 19... that I last saw the deceased alive on <u>1-18-59</u> 19... and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John O. Ralcher</u> M.D. <u>7930 Georgia Ave. Silver Spring, Md.</u>				DATE SIGNED <u>1-18-59</u>			
PHYSICIAN'S NAME (Type) <u>John O. Ralcher</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elijah</u>		22d. LOCATION (City, town, or county) (State) <u>Poolesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snodden</u> ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

767

Item 2 Film G238 1-30-59 et

CERTIFICATE OF DEATH

00835

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12koma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>			
c. LENGTH OF STAY in 1b <u>66 hrs</u>				d. STREET ADDRESS <u>1401 Montana Ave. N.E.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ellen Mary Hamer</u>				4. DATE OF DEATH <u>1-4-1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-29-67</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Patrick Ruane</u>				14. MOTHER'S MAIDEN NAME <u>Ellen McDonnell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>541.0 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anemia</u> DUE TO (c) <u>Hemorrhage From Duodenal Ulcer</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 days</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 days?</u> <u>8 days?</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Spring</u> , 1958, to <u>Jan 4</u> , 1959, that I last saw the deceased alive on <u>Jan. 3</u> , 1959, and that death occurred at <u>6:30 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James W. Egan</u>				ADDRESS (Street, city or town, state) <u>7720 Wisconsin Ave, Bethesda, Md-</u>			
DATE SIGNED <u>Same</u>							
PHYSICIAN'S NAME (Type) <u>JAMES W. EGAN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>Jan. 8, 1959</u>		<u>St. Joseph's</u>		<u>Hammond, Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chamber Co</u>				ADDRESS <u>1400 Chapin St NW</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 7 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1900</i>		5. PLACE OF BIRTH <i>Baltimore, Md.</i>	
6. OCCUPATION <i>Teacher</i>		7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF DEATH <i>Home</i>		10. TIME OF DEATH <i>10:30 AM</i>	
11. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>		13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>		19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>		25. SIGNATURE OF WITNESS <i>John Doe</i>	
26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>	
36. SIGNATURE OF WITNESS <i>John Doe</i>		37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>		43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>		49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>	
51. SIGNATURE OF WITNESS <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>		55. SIGNATURE OF WITNESS <i>John Doe</i>	
56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>	
66. SIGNATURE OF WITNESS <i>John Doe</i>		67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>	
71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>		73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>		79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF WITNESS <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>		85. SIGNATURE OF WITNESS <i>John Doe</i>	
86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>	
96. SIGNATURE OF WITNESS <i>John Doe</i>		97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

858

CERTIFICATE OF DEATH

Reg. Dist. No.

00837

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>OAKHAVEN REST HOME</u>				d. STREET ADDRESS <u>5923 4th St NW</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALBERT L. HANCOCK</u>				4. DATE OF DEATH Month Day Year <u>Jan 28 1959</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 11, 1876</u>			
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Inspector Fire Dept</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fire Dept</u>					
11. BIRTHPLACE (State or foreign country) <u>Ind</u>				12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>Thomas Hancock</u>				14. MOTHER'S MAIDEN NAME <u>Marie Richards</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ratie I Hancock</u> Address <u>5923 4th NW</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR HEMORRHAGE</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS</u> (c) <u>SENILITY</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>1950</u> , 19____, to <u>1-28-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-27-</u> , 19 <u>59</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE <u>Samuel A. Hillman</u>				M.D. <u>8829 FLOWER AVE</u>					
PHYSICIAN'S NAME (Type) <u>SAMUEL A. HILLMAN</u>				<u>SILVER SPRING, MD.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>1-31-59</u>		<u>Cedar Hill</u>		<u>Seatons Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neal Furens How</u>				ADDRESS <u>4812 26 Ave NW</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 2 '59</u>			
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED ALBERT L. HAMMOND</p>		<p>2. SEX MALE</p>	
<p>3. AGE 35</p>		<p>4. DATE OF BIRTH 1910</p>	
<p>5. PLACE OF BIRTH MASSACHUSETTS</p>		<p>6. DATE OF DEATH 1945</p>	
<p>7. PLACE OF DEATH MASSACHUSETTS</p>		<p>8. CAUSE OF DEATH HEART DISEASE</p>	
<p>9. MEDICAL HISTORY HEART DISEASE</p>		<p>10. OCCUPATION ENGINEER</p>	
<p>11. MARITAL STATUS MARRIED</p>		<p>12. NAME OF SPOUSE HELEN HAMMOND</p>	
<p>13. NAME OF PHYSICIAN DR. J. H. HAMMOND</p>		<p>14. NAME OF FUNERAL HOME WILLIAM HAMMOND</p>	
<p>15. NAME OF BURIAL PLACE WILLIAM HAMMOND</p>		<p>16. NAME OF CEMETERY WILLIAM HAMMOND</p>	
<p>17. NAME OF VENDOR WILLIAM HAMMOND</p>		<p>18. NAME OF MINISTER WILLIAM HAMMOND</p>	
<p>19. NAME OF CHURCH WILLIAM HAMMOND</p>		<p>20. NAME OF CLERGYMAN WILLIAM HAMMOND</p>	
<p>21. NAME OF MINISTER WILLIAM HAMMOND</p>		<p>22. NAME OF CLERGYMAN WILLIAM HAMMOND</p>	
<p>23. NAME OF MINISTER WILLIAM HAMMOND</p>		<p>24. NAME OF CLERGYMAN WILLIAM HAMMOND</p>	
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<p>97. NAME OF MINISTER WILLIAM HAMMOND</p>		<p>98. NAME OF CLERGYMAN WILLIAM HAMMOND</p>	
<p>99. NAME OF MINISTER WILLIAM HAMMOND</p>		<p>100. NAME OF CLERGYMAN WILLIAM HAMMOND</p>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 1. NAME OF DECEASED
 2. SEX
 3. AGE
 4. DATE OF BIRTH
 5. PLACE OF BIRTH
 6. DATE OF DEATH
 7. PLACE OF DEATH
 8. CAUSE OF DEATH
 9. MEDICAL HISTORY
 10. OCCUPATION
 11. MARITAL STATUS
 12. NAME OF SPOUSE
 13. NAME OF PHYSICIAN
 14. NAME OF FUNERAL HOME
 15. NAME OF BURIAL PLACE
 16. NAME OF CEMETERY
 17. NAME OF VENDOR
 18. NAME OF MINISTER
 19. NAME OF CHURCH
 20. NAME OF CLERGYMAN
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 99. NAME OF MINISTER
 100. NAME OF CLERGYMAN

859

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>10 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>5604 Wisconsin Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Clyde</u> Last <u>Harned</u>				4. DATE OF DEATH Month <u>1</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 12, 1886</u>	
9. AGE (In years lost birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>7</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>labor</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Issac Harned</u>				14. MOTHER'S MAIDEN NAME <u>ANNA Shade</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-30-3136</u>			
17. INFORMANT <u>Estella Harned</u> Address <u>5604 Wisc. Ave. Chevy Chase, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Angina Pectoris</u>						INTERVAL BETWEEN ONSET AND DEATH <u>45 min.</u> <u>1 1/2 hour</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec 30</u> , 19 <u>58</u> , to <u>Dec 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 26</u> , 19 <u>58</u> , and that death occurred at <u>11:15 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4413 Bradley Lane</u> DATE SIGNED <u>Bradley D. Hodgkins</u>							
ACTUAL SIGNATURE <u>Bradley D. Hodgkins</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Bradley D. Hodgkins</u>				4413 Bradley Lane, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/23/59</u>		<u>Nat. Memorial Cem.</u>		<u>Falls Church, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ashton		c. LENGTH OF STAY IN 1b 5 Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) Belmont Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) #1700# Silver Spring 56	
f. STREET ADDRESS 1700 Marymont Rd.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eugene Middle Harriss Last Harriss		4. DATE OF DEATH Month Jan. Day 17 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2 1876
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Saw Mill	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Henery Harriss		14. MOTHER'S MAIDEN NAME Eliza Virginia Shaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT William W. Evans		Address Same As 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apoplexy, thrombotic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral atherosclerosis DUE TO (c) 5 yrs.			INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 12, 1959 to Jan 17, 1959 , that I last saw the deceased alive on Jan 12, 1959 , and that death occurred at 11 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. D. Bonifant M.D.		ADDRESS (Street, city or town, state) Sandy Spring, Md.	
PHYSICIAN'S NAME (Type) A. D. BONIFANT		DATE SIGNED Jan 18/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 19 1959	
22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Olney Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		ADDRESS Laytonsville, Md	
24a. REC'D BY REGISTRAR JAN 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

388

STATE OF NEW YORK - BUREAU OF HEALTH

DECEASED

REPORTED BY

DATE

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF BIRTH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00840

861

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 2 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 705 Ritchie Avenue				d. STREET ADDRESS 705 Ritchie Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) MARY E HARVEY				4. DATE OF DEATH Month JANUARY Day 10 Year 19 59			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/7/74	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse (retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Silver Spring, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN BAILEY CLARK				14. MOTHER'S MAIDEN NAME EMMA A. HARDISTY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 578-01-0924		17. INFORMANT Address Mrs. Katherine Lorz, 705 Ritchie Ave. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) Hypertensive Vascular Disease INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 10 yrs. 10 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. — 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) —				20g. (County) —		20h. (State) —	
21. I certify that I attended the deceased from July , 19 54 , to Jan 10 , 19 59 , that I last saw the deceased alive on Jan 10 , 19 59 , and that death occurred at 1:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ralph F. Patten				DATE SIGNED Jan 10, 59			
PHYSICIAN'S NAME (Type) RALPH F. PATTEN				ADDRESS (Street, city or town, state) 8641- Collesville Road Silver Spring Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/13/59		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE JAN 13 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hanks			

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>12 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> <u>15</u>			
3. NAME OF DECEASED (Type or print) <u>Marion</u> First <u>Hawthorne</u> Middle <u>Hedges</u> Last				4. DATE OF DEATH <u>January</u> <u>6</u> <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-14-88</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR <u>3</u> Months <u>12</u> Days <u>12</u> Hours <u>19</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreign Operations Mem. U.S. Gov't</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Indiana</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Thomas Benton Hedges</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Mullen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Hospital Record</u>		17. INFORMANT <u>Hospital Record</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>MONTHS</u> <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(1) DUODENAL PEPTIC ULCER (2) DIABETES MELLITUS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1953</u> to <u>Jan 6, 1959</u> , that I last saw the deceased alive on <u>Jan 6, 1959</u> , and that death occurred at <u>8:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Seruch T. Kimble</u>				ADDRESS (Street, city or town, state) <u>929 Pershing Dr. Silver Spring, Md</u> DATE SIGNED <u>1/6/59</u>			
PHYSICIAN'S NAME (Type) <u>Seruch T Kimble</u>				529 Pershing Dr. Silver Spring, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodside</u>		22d. LOCATION (City, town, or county) (State) <u>Brinklow, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>JAN 12 59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knech</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

UNITED STATES DEPARTMENT OF HEALTH—BALTIMORE, 18										00842	
Item 18 Film 238 2-6-59 ams										Reg. Dist. No.	
862											
1. PLACE OF DEATH										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
o. COUNTY <u>BETHESDA</u>					MARYLAND					o. STATE <u>SAME</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>					c. LENGTH OF STAY IN 1b <u>4 YEARS</u>					b. COUNTY <u>MONTGOMERY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					e. STREET ADDRESS <u>4415 KINGSLEY AVE.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
First <u>ANNA</u> Middle <u>MARIA</u> Last <u>HEINTZE</u>					Month <u>JAN.</u> Day <u>24</u> Year <u>1959</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 7, 1877</u>		9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>12</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>				11. BIRTHPLACE (State or foreign country) <u>NEMECE (CZECHOSL)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD TABORSKY</u>					14. MOTHER'S MAIDEN NAME <u>MARIA TABORSKA</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>SON OSCAR HEINTZE, AS ABOVE</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA, TERMINAL</u> <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last: (b) <u>FRACTURE OF THE RIGHT FEMUR</u> DUE TO (c) <u>CANCER OF BREAST (R) WITH METASTASES</u>										INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>1-16-59</u> <u>3 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>53</u> , to <u>JAN. 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JAN. 22</u> , 19 <u>59</u> , and that death occurred at <u>5:22P</u> M, from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>FRANK S. HORVATH</u>					ADDRESS (Street, city or town, state) <u>1801 EYE ST. N.W.</u> DATE SIGNED <u>1-24-59</u>						
PHYSICIAN'S NAME (Type) <u>FRANK S. HORVATH, M.D.</u>					WASHINGTON, D.C.						
22a. BURIAL, CREMATION, REMOVAL <u>burial</u>			22b. DATE THEREOF <u>1/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven,</u>			22d. LOCATION (City, town, or county) (State) <u>Montgomery Co., Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co., 2901 14th St. N.W.,</u>					ADDRESS <u>Wash, D.C.</u>		24a. REC'D BY REGISTRAR <u>JAN 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>		

863

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 50 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Amy First Florence Middle HETT Last		4. DATE OF DEATH Month JANUARY Day 15 Year 19 59		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 22 Feb. 1879		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Carlton E. Bland		14. MOTHER'S MAIDEN NAME Margaret A. Craver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT John D. Hett		Address Same As 2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) brassica 593x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Nephritis & Nephrotosis DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	
20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 1/11/59 , 19 58 , to 1/15/59 , that I lost saw the deceased alive on 1/15/59 , 19 58 , and that death occurred at 10:04 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Sandy Spring Md. DATE SIGNED 1/17/59	
ACTUAL SIGNATURE J. W. Bird		PHYSICIAN'S NAME (Type) J. W. Bird		M.D. Sandy Spring Md.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 18 1959	
22c. NAME OF CEMETERY OR CREMATORY St. Johns Mt. Olivet		22d. LOCATION (City, town, or county) (State) Frederick Md.		23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		ADDRESS Laytonsville, Md		24a. REC'D BY REGISTRAR JAN 20 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MASSACHUSETTS
STATE DEPARTMENT OF HEALTH
BOSTON

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. W. BIRD		65		M		W		JAN 1 1880		BOSTON		JAN 10 1945		BOSTON		HEART DISEASE		NATURAL		J. W. BIRD		J. W. BIRD	
RESIDENT OF		BOSTON																					
OCCUPATION		BANKER																					
EDUCATION		COLLEGE																					
MARRIED		YES																					
SINGLE		NO																					
PREVIOUS MARRIAGES		NONE																					
PREVIOUS DEATHS		NONE																					
PREVIOUS INMATE		NO																					
PREVIOUS MENTAL		NO																					
PREVIOUS PHYSICAL		NO																					
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00845

864

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>1416 + Clifton St N.W.</u> <u>307 W. Clifton Terrace Apts</u>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>M</u> Last <u>Hitchcock</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/6/92</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henry Hitchcock</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Reed</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>yes</u> (If yes, give war or dates of service) <u>Army</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Son (Wallace Hitchcock)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO (c) <u>Diabetes Mellitus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u> <u>6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>1952</u> to <u>1-23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-22</u> , 19 <u>59</u> , and that death occurred at <u>7:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph A. Bailey</u> M.D.				ADDRESS (Street, city or town, state) <u>Wash. D.C.</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>JOSEPH A. BAILEY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>1/26/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) <u>Montgomery County, Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.H. Hines Co. by J.W. Dodd</u> ADDRESS <u>2901 14th St. N.W.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
				DATE <u>JAN 26 '59</u>			

865

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN TB <u>7 1/2</u> weeks				d. STREET ADDRESS <u>6029 Grosvenor Lane</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ella</u> Last <u>Hogland</u>				4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 20, 1914</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>6</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Hugh P. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Naomi Frund</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Wm. R. Sweeney-7609 Exeter Rd. Bgth. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> DUE TO <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Secondary anemia (Blood loss)</u> DUE TO <u>CAUSE</u> (c) <u>Adenocarcinoma of metastases</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>5 weeks</u> <u>undist</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 14, 1958</u> , to <u>1/26/1959</u> , that I last saw the deceased alive on <u>1/26/1959</u> , and that death occurred at <u>4:10 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen N. Jones</u> M.D.				ADDRESS (Street, city or town, state) <u>Rockville, Md.</u> DATE SIGNED <u>1/26/59</u>			
PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>				<u>Rockville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/28/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 28 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. P. P.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES M. SMITH		Male		45		10/15/1875		New York City		Carpenter		Married		White	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
10/25/1918		10:30 AM		Home		Heart Disease		Natural		J. M. Smith		J. M. Smith		J. M. Smith	
17. COUNTY		18. CITY		19. STATE		20. DISTRICT		21. WARD		22. BLOCK		23. LOT		24. HOUSE NO.	
Baltimore		Baltimore		Maryland		1st		1st		1st		1st		1st	
25. GRAVE NO.		26. GRAVE LOCATION		27. GRAVE ADDRESS		28. GRAVE CITY		29. GRAVE STATE		30. GRAVE DISTRICT		31. GRAVE WARD		32. GRAVE BLOCK	
100		100		100		100		100		100		100		100	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

866

CERTIFICATE OF DEATH

00847

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Nursing Home</u>				d. STREET ADDRESS <u>3018 P St., N. W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>LORRAINE F. HOLDER</u>				4. DATE OF DEATH <u>January 25 19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/20/1862</u>	
9. AGE (In years last birthday) <u>97</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>			
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Wm. Thomas Payne</u>				14. MOTHER'S MAIDEN NAME <u>Pricilla Richards Entwisle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Mrs. Jos. Ives</u>				Address <u>N. Y. City (Daughter)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>Senility</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>15 yrs.</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Incarcerated left femoral hernia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1-20 19 59</u> , to <u>1-25 19 59</u> , that I last saw the deceased alive on <u>1-20 19 59</u> , and that death occurred at <u>10 15</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edwin P. Parker</u> M.D.				ADDRESS (Street, city or town, state) <u>2015 R St., N. W. Wash., D.C.</u> DATE SIGNED <u>1/26/59</u>			
PHYSICIAN'S NAME (Type) <u>EDWIN P. PARKER</u> M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/28/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemt.</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. F. Brooks Sons</u>				ADDRESS <u>3034 M St. N. W., D.C.</u>		24a. REC'D BY REGISTRAR <u>JAN 28 1959</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>							

CERTIFICATE OF DEATH

1952

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1952

THE DEATH

DATE OF DEATH
1952

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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CAUSE OF DEATH

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

867

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>11 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8201 Cedar St.</u>				d. STREET ADDRESS <u>8201 Cedar St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nelly Eastwood Holmead</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-5-1885</u>	
9. AGE (In years last birth day) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N. J.</u>		11. BIRTHPLACE (State or foreign country) <u>N.S.C.</u>	
13. FATHER'S NAME <u>Elsworth Eastwood</u>				14. MOTHER'S MAIDEN NAME <u>Deanna Hoffman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>John H. Holmead - Steen 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>hypertension</u> (c) <u></u> DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>4 yrs.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1-18-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>				24a. REC'D BY REGISTRAR <u>2901 14th St. N.W. Washington 9, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

100-22

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE
HEALTH DEPT.

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF DEATH</p>	
<p>5. PLACE OF DEATH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. MEDICAL HISTORY</p>		<p>10. PHYSICAL EXAMINATION</p>		<p>11. LABORATORY EXAMINATIONS</p>		<p>12. POST-MORTEM EXAMINATION</p>	
<p>13. SIGNATURE OF MEDICAL EXAMINER</p>		<p>14. SIGNATURE OF CORONER</p>		<p>15. SIGNATURE OF JURY</p>		<p>16. SIGNATURE OF WITNESSES</p>	
<p>17. DATE OF EXAMINATION</p>		<p>18. TIME OF EXAMINATION</p>		<p>19. PLACE OF EXAMINATION</p>		<p>20. OTHER NOTES</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

868

CERTIFICATE OF DEATH

00849

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 5 1/2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rose Middle ALICE Last Hoopengardner				4. DATE OF DEATH Month 1 Day 1 Year 1959			
5. SEX female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/9/80	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78		IF UNDER 24 HRS. Days 78 Hours 78 Min. 78			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penn.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Nathan W. Mellott				14. MOTHER'S MAIDEN NAME Rebecca Garland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 217 32 2659		17. INFORMANT Medical Records Address Olney, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub. Arachnoid Hemorrhage DUE TO Hypertensive Cardio- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular Disease DUE TO known (c) known				INTERVAL BETWEEN ONSET AND DEATH 5 1/2 days NOT known			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec. 27, 1958 , to Jan. 1, 1959 , that I last saw the deceased alive on Jan. 1, 1959 , and that death occurred at 3:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Jack Schumacher M.D.							
PHYSICIAN'S NAME (Type) Jack Schumacher, M.D.				Gaithersburg, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 5 1959		22c. NAME OF CEMETERY OR CREMATORY Whips Cove		22d. LOCATION (City, town, or county) (State) Whips Cove Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber, Laytonville Md				24a. REC'D BY REGISTRAR JAN 7 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

MAINTAIN STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

1-1-1918

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1880</u></p>	
<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>1918</u></p>	
<p>6. Place of death: <u>NEW YORK</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>	
<p>8. Signature of physician: <u>[Signature]</u></p>	
<p>9. Signature of registrar: <u>[Signature]</u></p>	
<p>10. Date of registration: <u>1918</u></p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE VITALS ACT OF 1917.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

869

CERTIFICATE OF DEATH

Reg. Dist. No. 215

00850

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 20 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 6024 Cheshire Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James Reuben HOOPER		4. DATE OF DEATH Month Day Year January 22 19 59	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-1-89 1879
9. AGE (In years last birthday) 78 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundryman		10b. KIND OF BUSINESS OR INDUSTRY Laundry	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (Unknown) HOOPER		14. MOTHER'S MAIDEN NAME Frances HOOPER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-05-8309	
17. INFORMANT (SinL) AArne Tervo, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, hypostatic 794x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General debilitation DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Bethesda		(County) (State)	
21. I certify that I attended the deceased from January 2 19 59 , to January 22 19 59 , that I last saw the deceased alive on January 22 19 59 and that death occurred at 10:50A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE K. F. Spence, Jr.		DATE SIGNED 1-22-59	
PHYSICIAN'S NAME (Type) K. F. SPENCE, JR.		ADDRESS (Street, city or town, state) Bethesda 14, Maryland	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-26-59	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE S. H. Hines Funeral Home		ADDRESS 2901 14th St, NW, Wash. DC	
24a. REC'D BY REGISTRAR JAN 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

769

CERTIFICATE OF DEATH

00851

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>23 days</u>				d. STREET ADDRESS <u>120 Hamilton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Louise</u> Last <u>Howard</u>				4. DATE OF DEATH Month <u>1</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-27-08</u>	
9. AGE (In years lost birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Eugene Raelke</u>				14. MOTHER'S MAIDEN NAME <u>XX Crissie Rickerd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 Days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Febr.</u> , 19 <u>54</u> , to <u>1-3</u> , 19 <u>59</u> , that I lost s/he the deceased alive on <u>1-2</u> , 19 <u>59</u> , and that death occurred at <u>5:45</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9241 Col. Blvd. Silver Spring, Md.</u> DATE SIGNED <u>1-3-59</u>							
ACTUAL SIGNATURE <u>J. Marion Benshead</u> M.D.				PHYSICIAN'S NAME (Type) <u>J. Marion Benshead</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>1/6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>	
22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Gaska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 7 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Clifton S. Kraus</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

770

CERTIFICATE OF DEATH

00852

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carl G. Hultgren		4. DATE OF DEATH Month Jan. Day 31 , Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1884
9. AGE (In years last birthday) 64 7/4 yrs.		10. IF UNDER 1 YEAR Months 11 Days 12	11. IF UNDER 24 HRS. Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bureau of Standards		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.-Ret.	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Augusta Hultgren		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577-16-4859	
17. INFORMANT Ida M. Hultgren - wife - as above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Macular & Brain DUE TO (c) Carcinoma of Lung INTERVAL BETWEEN ONSET AND DEATH 4 days 2 days 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 20 , 19 58 , to Jan 31 , 19 59 , that I last saw the deceased alive on Jan 30 , 19 59 , and that death occurred at 8:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3701 Leland St., Chevy Chase, Md. DATE SIGNED 1-31-59			
ACTUAL SIGNATURE J. Raymond Ready M.D.			
PHYSICIAN'S NAME (Type) J. RAYMOND READY			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/3/59	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE FEB 4 '59	
		24b. REGISTRAR'S SIGNATURE Christina S. H.	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOTED

Heavy Chase

1908 Police

1908 Police

1908 Police

1908 Police

1908 Police

1908 Police

1908 Police

1908 Police

870

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 46 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn 9			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS c/o Mr. J. Jensen, 619 80th St.			
3. NAME OF DECEASED (Type or print) First Ellen Middle (None) Last Ingwersen				4. DATE OF DEATH Month January Day 16 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH August 28, 1914	
9. AGE (In years last birthday) yrs. 44		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary				10b. KIND OF BUSINESS OR INDUSTRY U. S. Government		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Ingwersen				14. MOTHER'S MAIDEN NAME Olga Danielsen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma breast with bony metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) central nervous system depression DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from December 1, 19 58 to January 16, 19 59 that I last saw the deceased alive on January 16, 19 59 and that death occurred at 7:15a M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul Schwab				DATE SIGNED 1-16-59			
PHYSICIAN'S NAME (Type) Paul Schwab, M. D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/20/59		22c. NAME OF CEMETERY OR CREMATORY CYPRESS HILLS		22d. LOCATION (City, town, or county) (State) QUEENS, NEW YORK	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Paulus Sons				ADDRESS 1756 Pa. Ave., N.W. DC		24a. REC'D BY REGISTRAR DATE JAN 20 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

The Clinical Center
National Institute of Health
Bethesda, Maryland

January 12, 1952

1200 B. B. 12

January 12, 1952

December 1, 1951

January 12, 1952

1200 B. B. 12

1200 B. B. 12

1200 B. B. 12

None

The Clinical Center, Bethesda, Maryland

John L. Lister

John L. Lister

Secretary

U. S. Government

New York

Female

August 22, 1914

(Born)

Irishman

January 10

The Clinical Center, Bethesda, Maryland

Brooklyn, N.Y.

MAINTAIN

1200 B. B. 12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00854

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John		c. LENGTH OF STAY IN 1b X Cabin John	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fire House, Cabin John		d. STREET ADDRESS 6914 Seven Locks Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John Raymond Iverson		4. DATE OF DEATH Month Jan Day 6 Year 1959	
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/11/1903
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John R. Iverson		14. MOTHER'S MAIDEN NAME Daisy Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-10-1959	
22c. NAME OF CEMETERY OR CREMATORY MOSES CEMETERY		22d. LOCATION (City, town, or county) (State) Cabin John MD	
23. FUNERAL DIRECTOR'S SIGNATURE W. ERNEST JARVIS Co.		24a. REC'D BY REGISTRAR 1432 YOU ST. NW WASHINGTON D.C.	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
OCCUPATION		EDUCATION		MARRIAGE		SINGLE		MARRIED	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
HISTORY		PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		X-RAY EXAMINATIONS		PATHOLOGICAL FINDINGS	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		CITY	
OFFICE OF THE MEDICAL EXAMINER		ADDRESS		CITY		COUNTY		STATE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00855

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

872 items 1,3,8,9,13 Film G238 2-2-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CABIN JOHN Brookmont c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING d. STREET ADDRESS 11,719 COLLEGE VIEW DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Satoru Middle Harvey Last IWATA		4. DATE OF DEATH Month JAN. Day 19 Year 1959			
5. SEX MALE	6. COLOR OR RACE Mongolian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/16/03	9. AGE (In years full birthday) 56 yrs.	IF UNDER 1 YEAR Months 5 Days 53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't. Branch Chief of Geographic		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T.		11. BIRTHPLACE (State or foreign country) FRESNO, CALIFORNIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME TASOJI IWATA, Tasoji		14. MOTHER'S MAIDEN NAME SUYE SAKUMA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 564-20-5316		17. INFORMANT Mr. Harvey M. Iwata, 11,719 College View Drive Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion - 416X DUE TO (b) Rheumatic Heart Disease - 10 yr. DUE TO (c) 5 min.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE John G. Ball		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/19/59	
EXAMINER'S NAME (Type) JOHN G. BALL		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 1/24/59		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY	
22d. LOCATION (City, town, or county) PRINCE GEO. COUNTY, MARYLAND		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR JAN 22 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. House					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

873

CERTIFICATE OF DEATH

00856

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>3914 McKinley St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>J</u> Last <u>Jamieson</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 7, 1880</u>	
9. AGE (In years lost birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Dept. of Agri.</u>		11. BIRTHPLACE (State or foreign country) <u>CONN.</u>	
13. FATHER'S NAME <u>George A. JAMIESON</u>				14. MOTHER'S MAIDEN NAME <u>EDITH BURNS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Charlotte H. Jamieson - as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right hemiplegia, severe</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia, terminal due to nephrosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u></u> Day <u></u> Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street-office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> to <u>Jan 26</u> <u>1959</u> , that I last saw the deceased alive on <u>Jan 26</u> <u>1959</u> , and that death occurred at <u>9:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3921 Ingomar St. N.W.</u> DATE SIGNED <u>1.27.59</u>							
ACTUAL SIGNATURE <u>Stewart Clapp</u>				M.D. <u>Wash 15 D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey, Bethesda 14, Md.</u>				24a. REG'D BY REGISTRAR DATE <u>JAN 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

874

CERTIFICATE OF DEATH

00857

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier Ranier 1616, 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS 4315-30th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Donald Middle Oliver Last John			4. DATE OF DEATH Month January Day 8 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 25, 1937		9. AGE (In years last birthday) 21 yrs. 0 Months 7 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plater & Engraver		10b. KIND OF BUSINESS OR INDUSTRY Engraving		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Donald L. John		
14. MOTHER'S MAIDEN NAME Mildred Brewer			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. Unascertainable			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of the right coronary and free cusp of aortic valve. DUE TO 741 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fibrinous pericarditis with massive effusion DUE TO Bacterial endocarditis, aortic & tricuspid valve (c) source of infection, purulent left suprapatellar hursitis					INTERVAL BETWEEN ONSET AND DEATH 1 wk. ? 1-2 days 3 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from December 29, 1958 , to January 8, 1959 , that I last saw the deceased alive on January 8, 1959 , and that death occurred at 5:40 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE John P. Nasou M.D.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 1-9-59	
PHYSICIAN'S NAME (Type) John P. Nasou, M. D.		National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-12-59	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda 14, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 12 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

REMARKS

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771
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oak Haven Rest Home				d. STREET-ADDRESS 424 Oneida Pl., N.W. 547 Albany Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) G. M. A. B. Johnson				4. DATE OF DEATH Month Jan. Day 7 Year 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/8/1868	
9. AGE (In years lost birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Benjamin Hellows				14. MOTHER'S MAIDEN NAME Emma Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Elizabeth M. Johnson				Address Wash. DC 424 Oneida Pl. N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Influenza Syndrome 481X DUE TO non specific Parotitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Weakness and inanition (c) Old age 91 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old age 91 INTERVAL BETWEEN ONSET AND DEATH 10 days 2 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/2/1958 to 1/7/1959 , that I last saw the deceased alive on 1/6/1959 , and that death occurred at 7:15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles H. Wolohon				ADDRESS (Street, city or town, state) 500 Underwood ST NW Washington			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/10/1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Wolohon				24a. REC'D BY REGISTRAR DATE JAN 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

875

CERTIFICATE OF DEATH

00859

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 916 - Hollywood Ave.				d. STREET ADDRESS 1916 - Hollywood Ave.			
3. NAME OF DECEASED (Type or print) First Clarence Middle Ellsworth Last Kane				4. DATE OF DEATH Month Jan. Day 28 Year 19 59			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1898	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Helper Retired				10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.			
11. BIRTHPLACE (State or foreign country) Baltimore, Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 705-05-5253			
17. INFORMANT Rosalie Hansford				Address same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: Hemorrhage, Esophageal Varices 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma of Liver (c) Carcinoma, GASTRIC							INTERVAL BETWEEN ONSET AND DEATH 14.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19 59				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from October, 19 58 to January, 19 59 , that I last saw the deceased alive on Jan. 29, 19 59 , and that death occurred at 8:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Bar J. Vosger				ADDRESS (Street, city or town, state) 1222 Monroe St. N.C.			
PHYSICIAN'S NAME (Type) AZAD J. Vosger				DATE SIGNED Washington 17, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1-31-59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home Inc.				ADDRESS Mt. Rainier, Md.		24a. REC'D BY REGISTRAR FEB 3 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - JANUARY 19

Marxist Kasper Peter

CERTIFICATE OF DEATH

00860

Reg. Dist. No.

772

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN TB <u>14 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington San. & Hospital</u>				d. STREET ADDRESS <u>1206 Lebanon St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph (NMN) Kaplan</u>				4. DATE OF DEATH Month Day Year <u>JAN. 10 1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/12/32</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Scrap Metal Dealer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>			
11. BIRTHPLACE (State or foreign country) <u>Russia</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>Harry Kaplan</u>				14. MOTHER'S MAIDEN NAME <u>Ethel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Hosp. Records</u>			
17. INFORMANT Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Arteriosclerotic heart disease, in coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Thrombosis & Myocardial Infarction</u> (c) <u>Arteriosclerotic heart disease, in coronary</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic heart failure</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12-27, 1958</u> to <u>1-10, 1959</u> that I last saw the deceased alive on <u>1-10, 1959</u> , and that death occurred at <u>2:00 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas H Wol: H: N</u>				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave</u> DATE SIGNED <u>1/10/59</u>			
PHYSICIAN'S NAME (Type) <u>Chas H Wol: H: N</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-11-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Levine</u> ADDRESS <u>2100 Contours Place</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 4, 17, 9 Film Q237 1/12/59 b12
876
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

00861

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Mary E. Keene</u>		4. DATE OF DEATH Month Day Year <u>1</u> <u>4</u> <u>59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 26, 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Mr. Harry Carter</u>		14. MOTHER'S MAIDEN NAME <u>Mary Emily</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Harry Carter</u>		18. ADDRESS <u>10414 Parkwood Dr Kensington, Mary.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart disease</u> DUE TO (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1) Myxedema 2) Vitamin deficiency - Multiple</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 23, 1958</u> , to <u>1-4-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-1-</u> , 19 <u>59</u> , and that death occurred at <u>8:50 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Morris Perry</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>11602 Georgia Ave Silver Spring Md. 1-4-59</u>	
PHYSICIAN'S NAME (Type) <u>Morris Perry</u>		<u>Silver Spring Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/7/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JOHN 7</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Keene</u>	

773
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hosp.</u>				d. STREET ADDRESS <u>307 Warrenton Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Leedy</u> Last <u>Kessinger</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-16-10</u>		9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew J. Kessinger</u>				14. MOTHER'S MAIDEN NAME <u>Leedy Ella MacKessinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>263-07-0044</u>		17. INFORMANT <u>Andrew J. Kessinger, Silver Spring, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Hour o. m. p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Jan 16</u> , 19 <u>53</u> , to <u>Jan 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 20</u> , 19 <u>59</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Merrill M. Cross</u> M.D.				ADDRESS (Street, city or town, state) <u>8248 George Ave - Silver Spring Maryland</u>			
DATE SIGNED <u>1/27/59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u> <u>Raymond A. Giska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>JAN 29 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
793
CERTIFICATE OF DEATH

00863

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. LENGTH OF STAY IN 1b <i>10 months</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Congressional Spring Sanatorium</i>			d. STREET ADDRESS <i>1300 Reading Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Alverda C.</i> Middle <i>Kingdon</i> Last <i>Kingdon</i>			4. DATE OF DEATH Month <i>JAN.</i> Day <i>3rd</i> Year <i>19 59</i>		
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/4/1884</i>	9. AGE (In years lost birthday) <i>74 yrs.</i>	IF UNDER 1 YEAR Months <i>11</i> Days <i>27</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>
13. FATHER'S NAME <i>John Kingdon</i>			14. MOTHER'S MAIDEN NAME <i>Alverda Apple</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Miss Mary Rose Kingdon</i> Address <i>300 Reading Ave. Rockville, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332x cerebral anoxia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>cerebral thrombosis</i> DUE TO (c) <i>cerebral arteriosclerosis</i>					INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> <i>10 days</i> <i>Indef.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <i>o. n.</i> Month <i>19</i> Day <i>19</i> Year <i>19 59</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <i>Feb 1, 19 55</i> , to <i>1/3/ 19 59</i> , that I last saw the deceased alive on <i>1/3/ 19 59</i> , and that death occurred at <i>6:30 A. M.</i> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Stephen N. Jones</i>		M.D. <i>Rockville, Md.</i>		DATE SIGNED <i>1/3/59</i>	
PHYSICIAN'S NAME (Type) <i>Stephen N. JONES</i>		Rockville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <i>Rockville Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Rockville, Md.</i>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>			ADDRESS <i>Rockville, Maryland</i>		
24a. REC'D BY REGISTRAR <i>Jan 7 '59</i>			24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>		

CERTIFICATE OF DEATH

1933

1. NAME OF DECEASED ROBERT J. KOSKOVIC		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 1, 1933		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Chicago, Ill.	
10. DATE OF BIRTH March 17, 1898		11. PLACE OF BIRTH Chicago, Ill.		12. OCCUPATION Engineer	
13. MARITAL STATUS Married		14. NAME OF SPOUSE Mary E. Koskovic		15. DATE OF MARRIAGE June 15, 1920	
16. NAME OF FATHER John J. Koskovic		17. NAME OF MOTHER Elizabeth A. Koskovic		18. DATE OF DEATH OF FATHER March 10, 1925	
19. DATE OF DEATH OF MOTHER April 5, 1910		20. NAME OF DECEASED'S PHYSICIAN Dr. J. H. Smith		21. NAME OF DECEASED'S SURGEON Dr. J. H. Smith	
22. NAME OF DECEASED'S ATTENDING NURSE Mrs. J. E. Koskovic		23. NAME OF DECEASED'S FUNERAL HOME St. Mary's Funeral Home		24. NAME OF DECEASED'S BURIAL PLACE St. Mary's Cemetery	
25. NAME OF DECEASED'S INTERMENT PLACE St. Mary's Cemetery		26. NAME OF DECEASED'S INTERMENT DATE April 5, 1933		27. NAME OF DECEASED'S INTERMENT TIME 10:30 AM	
28. NAME OF DECEASED'S INTERMENT PLACE St. Mary's Cemetery		29. NAME OF DECEASED'S INTERMENT DATE April 5, 1933		30. NAME OF DECEASED'S INTERMENT TIME 10:30 AM	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

877

CERTIFICATE OF DEATH

Reg. Dist. No.

00864

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN TB <u>8 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville 26</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>74 Suburban Hospital</u>				d. STREET ADDRESS <u>524 Calvin Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>Agnes</u> Last <u>Kirby</u>				4. DATE OF DEATH Month <u>January</u> Day <u>28</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 24, 1890</u>		9. AGE (In years lost birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Brooklyn, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Timmins</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Norman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Son</u> <u>Mr. Jerome F. Kirby</u>		Address <u>As above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Acute Peritonitis</u> <u>550.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Suppurative Appendicitis & Perforation</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>1-27</u> , 19 <u>59</u> , to <u>1-28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-27</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>W. G. Hall</u> M.D. <u>615 W. Montgomery Ave. Rockville, Md.</u> <u>1-28-59</u> PHYSICIAN'S NAME (Type) <u>W. G. Hall</u> 615 Montg. Ave., Rockville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/31/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2 COPIES

Notified 7:40 A.M. 1-28-59

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES EARL RAY		Male		35		April 14, 1928		Memphis, Tennessee	
6. OCCUPATION		7. MARITAL STATUS		8. EDUCATION		9. RELIGION		10. RACE	
Attorney		Single		High School		Methodist		White	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. PLACE OF DEATH		14. DATE OF DEATH		15. TIME OF DEATH	
Myocardial Infarction		Natural		Home		April 6, 1963		10:15 AM	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signatures]		[Signature]		[Signature]	
21. CITY OF DEATH		22. COUNTY OF DEATH		23. STATE OF DEATH		24. COUNTRY OF DEATH		25. ZIP CODE	
Baltimore		Baltimore		Maryland		United States of America		21201	

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE REGISTRAR AND THE PHYSICIAN. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THE INFORMATION FURNISHED IS TRUE AND CORRECT. IT IS THE DUTY OF THE PHYSICIAN TO SIGN THE CERTIFICATE OF DEATH AND TO FURNISH THE CAUSE OF DEATH.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G237 1-19-59 et

878

CERTIFICATE OF DEATH

00865

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN lb 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				d. STREET ADDRESS Route #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lennie Middle Mae Last Kirk				4. DATE OF DEATH Month January Day 8 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9.12.94	
9. AGE (In years last birthday) 64 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Henry C. Flanary				14. MOTHER'S MAIDEN NAME Gladys Ann Willis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NO			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes (coma) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, Hemiplegia right DUE TO (c) Hypothyroidism							INTERVAL BETWEEN ONSET AND DEATH 5 years 2 years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 1 , 19 59 , to January 8 , 19 59 , that I last saw the deceased alive on January 8 , 19 59 , and that death occurred at 11:17 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. W. Bird, M. D.				ADDRESS (Street, city or town, state) Sandy Spring, Maryland			
DATE SIGNED 1/8/59							
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 10 59		22c. NAME OF CEMETERY OR CREMATORY Jonesville		22d. LOCATION (City, town, or county) (State) Jonesville Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber				ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR JAN 12 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED

NAME

AGE

SEX

RACE

RELIGION

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00866

879

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 75 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Ann Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Annapolis d. STREET ADDRESS 15 Monroe Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Arthur KLEIS		4. DATE OF DEATH Month Day Year January 14 19 59	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-27-04
9. AGE (In years last birthday) 54		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank M. KLEIS		14. MOTHER'S MAIDEN NAME Anna Lillian Boniarski	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (W) Mrs. Audrey M. Kleis, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized inanition DUE TO (c) Multiple fistulas (colon) and abscesses			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. INTERVAL BETWEEN ONSET AND DEATH 4 days 3 months 4 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from October 31 , 19 58 , to January 14 , 19 59 , that I last saw the deceased alive on January 13 , 19 59 , and that death occurred at 4:40A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NMMC 1-14-59			
ACTUAL SIGNATURE J. M. Young PHYSICIAN'S NAME (Type) J. M. YOUNG, LT, MC, USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 1-17-59			
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet			
22d. LOCATION (City, town, or county) (State) Baltimore Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE B.L. Hopping ADDRESS B.L. Hopping Funeral Home, Annapolis, Md.			
24a. REC'D BY REGISTRAR JAN 16 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of jury		12. Signature of witnesses	
13. Signature of funeral home		14. Signature of cemetery		15. Signature of undertaker		16. Signature of other parties	
17. Signature of health officer		18. Signature of board of health		19. Signature of state board of health		20. Signature of federal health officer	
21. Signature of state board of health		22. Signature of federal health officer		23. Signature of state board of health		24. Signature of federal health officer	
25. Signature of state board of health		26. Signature of federal health officer		27. Signature of state board of health		28. Signature of federal health officer	
29. Signature of state board of health		30. Signature of federal health officer		31. Signature of state board of health		32. Signature of federal health officer	
33. Signature of state board of health		34. Signature of federal health officer		35. Signature of state board of health		36. Signature of federal health officer	
37. Signature of state board of health		38. Signature of federal health officer		39. Signature of state board of health		40. Signature of federal health officer	
41. Signature of state board of health		42. Signature of federal health officer		43. Signature of state board of health		44. Signature of federal health officer	
45. Signature of state board of health		46. Signature of federal health officer		47. Signature of state board of health		48. Signature of federal health officer	
49. Signature of state board of health		50. Signature of federal health officer		51. Signature of state board of health		52. Signature of federal health officer	
53. Signature of state board of health		54. Signature of federal health officer		55. Signature of state board of health		56. Signature of federal health officer	
57. Signature of state board of health		58. Signature of federal health officer		59. Signature of state board of health		60. Signature of federal health officer	
61. Signature of state board of health		62. Signature of federal health officer		63. Signature of state board of health		64. Signature of federal health officer	
65. Signature of state board of health		66. Signature of federal health officer		67. Signature of state board of health		68. Signature of federal health officer	
69. Signature of state board of health		70. Signature of federal health officer		71. Signature of state board of health		72. Signature of federal health officer	
73. Signature of state board of health		74. Signature of federal health officer		75. Signature of state board of health		76. Signature of federal health officer	
77. Signature of state board of health		78. Signature of federal health officer		79. Signature of state board of health		80. Signature of federal health officer	
81. Signature of state board of health		82. Signature of federal health officer		83. Signature of state board of health		84. Signature of federal health officer	
85. Signature of state board of health		86. Signature of federal health officer		87. Signature of state board of health		88. Signature of federal health officer	
89. Signature of state board of health		90. Signature of federal health officer		91. Signature of state board of health		92. Signature of federal health officer	
93. Signature of state board of health		94. Signature of federal health officer		95. Signature of state board of health		96. Signature of federal health officer	
97. Signature of state board of health		98. Signature of federal health officer		99. Signature of state board of health		100. Signature of federal health officer	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.



Items 18&21 Film 238 2-4-59 ams
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00867

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Chevy Chase		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3518 Bradley Lane			e. STREET ADDRESS 3518 Bradley Lane		
3. NAME OF DECEASED (Type or print) CHRISTOPHER H. KOTSCHNIG			4. DATE OF DEATH January 24, 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1928		9. AGE (in years last birthday) 30 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Actor		10b. KIND OF BUSINESS OR INDUSTRY Theater		11. BIRTHPLACE (State or foreign country) Switzerland	12. CITIZEN OF WHAT COUNTRY US
13. FATHER'S NAME Walter Kotschnig			14. MOTHER'S MAIDEN NAME Elined Prys		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Walter Kotschnig-Item# 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide poisoning 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Found dead in closed car in closed garage at home					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/24/59	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 1/26/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
22d. LOCATION (City, town, or county)		(State) Suitland, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland			ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JAN 28 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus					

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CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 5 hours d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 44 Forrester Street, S. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frederick Joseph KRUEGER				4. DATE OF DEATH Month Day Year January 27 1959			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-27-59	
9. AGE (In years last birthday) yrs.		10. AGE (In years last birthday) yrs.		11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - - - -			
13. FATHER'S NAME John W. KRUEGER				14. MOTHER'S MAIDEN NAME Shirley Jo FREEMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (F) John W. Krueger, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Alectosis 759.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Choanal Atresia DUE TO (c) Multiple Congenital Anomalies						INTERVAL BETWEEN ONSET AND DEATH 5 hr 5 hr 5 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 27, 1959 , to January 27, 1959 , that I last saw the deceased alive on January 27, 1959 , and that death occurred at 8:42 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NMMC 1-27-59							
ACTUAL SIGNATURE Kenneth W. Sell M.D.				PHYSICIAN'S NAME (Type) Kenneth W. SELL, LT, MC, USN Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial-Shipment 1-29-59		1-29-59		Catholic Cemetery		Emporia Kansas	
23. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home, 4748 Wisc. Ave. NW, Washington				24a. REC'D BY REGISTRAR DATE JAN 29 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5, 1928		MOBILE, ALABAMA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		WHITE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
APR 4, 1968		MEMPHIS, TENNESSEE		HEART DISEASE		NATURAL		12345	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APR 5, 1968		APR 5, 1968		APR 5, 1968		APR 5, 1968		APR 5, 1968	

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CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY New York ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 52 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. STREET ADDRESS 685 West End Ave.			
3. NAME OF DECEASED (Type or print) First Howard Middle Bennett Last LEONARD				4. DATE OF DEATH Month January Day 15 Year 19 59			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 12-6-09	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate				10b. KIND OF BUSINESS OR INDUSTRY Iowa		11. BIRTHPLACE (State or foreign country) Iowa	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Oliver H. LEONARD				14. MOTHER'S MAIDEN NAME Nellie BENNETT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) Yes 6/42 to 6/45				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe general anoxia (c) Lymphosarcoma - wide system involvement PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 mo 3 years				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bethesda				20g. (County) Maryland		20h. (State) Maryland	
21. I certify that I attended the deceased from November 24, 19 58 , to January 15, 19 59 , that I last saw the deceased alive on January 15, 19 59 , and that death occurred at 10:23A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE F. H. O'Connell				ADDRESS (Street, city or town, state) U. S. Naval Hospital			
DATE SIGNED 1-15-59							
PHYSICIAN'S NAME (Type) F. H. O'CONNELL, LT, MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				22b. DATE THEREOF 1-16-59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hills	
22d. LOCATION (City, town, or county) Suitland				22e. (State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR JAN 19 59	
24b. REGISTRAR'S SIGNATURE Christina E. Hume							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		M		W		4-4-68		MEMPHIS, TENN.	
BIRTH DATE		BIRTH PLACE		MARRIAGE DATE		MARRIAGE PLACE		EDUCATION		OCCUPATION	
1-1-28		MEMPHIS, TENN.		1-1-55		MEMPHIS, TENN.		HIGH SCHOOL		PUBLISHER	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		DECEASED'S RESIDENCE		DECEASED'S ADDRESS	
JAMES EARL RAY		LUCILLE RAY		PUBLISHER		HOUSEWIFE		1125 S. GUYTON ST.		MEMPHIS, TENN.	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTRATION NO.		DATE OF REGISTRATION		PLACE OF REGISTRATION	
HEART DISEASE		NATURAL		1-1-68		1-1-68		4-4-68		MEMPHIS, TENN.	
PHYSICIAN'S SIGNATURE		PHYSICIAN'S NAME		PHYSICIAN'S ADDRESS		PHYSICIAN'S PHONE		PHYSICIAN'S LICENSE NO.		PHYSICIAN'S EXPIRATION DATE	
[Signature]		JAMES EARL RAY		1125 S. GUYTON ST.		MEMPHIS, TENN.		1-1-68		1-1-68	
DECEASED'S SIGNATURE		DECEASED'S NAME		DECEASED'S ADDRESS		DECEASED'S PHONE		DECEASED'S LICENSE NO.		DECEASED'S EXPIRATION DATE	
[Signature]		JAMES EARL RAY		1125 S. GUYTON ST.		MEMPHIS, TENN.		1-1-68		1-1-68	
DECEASED'S RELATIVE'S SIGNATURE		DECEASED'S RELATIVE'S NAME		DECEASED'S RELATIVE'S ADDRESS		DECEASED'S RELATIVE'S PHONE		DECEASED'S RELATIVE'S LICENSE NO.		DECEASED'S RELATIVE'S EXPIRATION DATE	
[Signature]		LUCILLE RAY		1125 S. GUYTON ST.		MEMPHIS, TENN.		1-1-68		1-1-68	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

774tem 22 FilmG238 1-30-59 at
CERTIFICATE OF DEATH

00879

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Takoma Park Maryland</u>		c. LENGTH OF STAY IN 1b <u>2 hrs. - 26 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		d. STREET ADDRESS <u>5711 Chillum Hgts Dr.,</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lewis</u>		4. DATE OF DEATH Month Day Year <u>1 - 20 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-20-59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. Months Days Hours Min. <u>2 26</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Hugo Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Mae Flowers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mother's record</u>	
17. INFORMANT <u>Mother's record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Julius S. River M.D.</u>		M.D. <u>6480 New Hampshire Ave., Takoma Park, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Julius S. River M.D.</u>		<u>6480 New Hampshire Ave., Takoma Park, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>---</u>		22b. DATE THEREOF <u>1-23-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hospital disposal</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>28 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

883

CERTIFICATE OF DEATH

Reg. Dist. No.

00871

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN 1b Since 1/1/59	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3000 McComas Avenue		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE	
3. NAME OF DECEASED (Type or print) First Middle Last JULIUS CHRISTIAN LINK		4. DATE OF DEATH Month Day Year JAN. 8 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/3/79
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Diamond setter (retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHAN CHRISTIAN LINK		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 35-09-7528	
17. INFORMANT Mr. William J. Link, 6915 Ridgewood Ave., Chevy Chase, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, urinary bladder 181.0 DUE TO metastasis to rectum & other adjacent structures, & to skull(?) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 20 yrs. 34 yrs. ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1948 , to Jan. 8, 1959 , that I last saw the deceased alive on Jan. 6, 1959 , and that death occurred at 2:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10,620 1st Ave. DATE SIGNED 1-8-59			
ACTUAL SIGNATURE Philip H. Varner		M.D. 10,620 1st Ave.	
PHYSICIAN'S NAME (Type) PHILIP H. VARNER			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF 1/10/59	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY	22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		24a. REC'D BY REGISTRAR DATE JAN 12 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

883

NAME OF DECEASED		DATE OF DEATH	
JAMES H. BROWN		JAN 15 1950	
PLACE OF DEATH		AGE	
BALTIMORE, MARYLAND		65	
OCCUPATION		CAUSE OF DEATH	
RETIRED		HEART DISEASE	
DATE OF BIRTH		PLACE OF BIRTH	
JAN 1 1885		BALTIMORE, MARYLAND	
MARRIAGE		EDUCATION	
MARRIED		HIGH SCHOOL	
DATE OF MARRIAGE		MILITARY SERVICE	
JAN 15 1910		NONE	
PREVIOUS DEATHS		HISTORICAL DATA	
NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. BROWN		J. H. BROWN	
DATE		DATE	
JAN 15 1950		JAN 15 1950	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH, BALTIMORE, MD.

TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE INFORMATION CONTAINED HEREIN IS TRUE AND CORRECT.

10 MONTHS OF VALIDITY EXTENDING TO JAN 1 1951

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00872

884

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 108 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Scranton 75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS 105 South 7th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Diane Marie Lisak			4. DATE OF DEATH Month Day Year January 8, 19 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 3, 1950		9. AGE (In years last birthday) 8 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Lisak			14. MOTHER'S MAIDEN NAME Anna Caranda		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction 756.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Undiagnosed disease of intestine DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH 18 hours 8 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Scranton, Pennsylvania	
21. I certify that I attended the deceased from September 22, 19 58 , to January 8, 19 59 , that I last saw the deceased alive on January 8, 19 59 , and that death occurred at 12:30 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/8/59 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 1/8/59			22b. DATE THEREOF 1/8/59		22c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery
22d. LOCATION (City, town, or county) (State) Scranton, Pennsylvania			22e. REC'D BY REGISTRAR Robert A. Pumphrey		
22f. REGISTRAR'S SIGNATURE Robert A. Pumphrey			22g. REGISTRAR'S SIGNATURE Bethesda, Maryland		

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

Eugene B. Feigelson

M.D.

PHYSICIAN'S NAME (Type)

*Eugene B. Feigelson, M.D.**The Clinical Center*
National Institutes of Health
*Bethesda 14, Maryland**1/8/59*22a. BURIAL, CREMATION, REMOVAL (Specify)
Bur-Transit 1/8/5922b. DATE THEREOF
1/8/5922c. NAME OF CEMETERY OR CREMATORY
Cathedral Cemetery22d. LOCATION (City, town, or county) (State)
Scranton, Pennsylvania

22e. REGISTRAR'S SIGNATURE

Robert A. Pumphrey

ADDRESS

Bethesda, Maryland

22f. REC'D BY REGISTRAR

Robert A. Pumphrey

22g. REGISTRAR'S SIGNATURE

Arthur L. Haase

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 15 1910	
RESIDENCE		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
1000 N. E. ST.		HOSPITAL		DISEASE		SUICIDE		1234	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		SIGNED	
Carpenter		High School		Roman Catholic		Married		J. H. HARRIS	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		SIGNED	
JAN 15 1865		BALTIMORE		JAN 15 1910		HOSPITAL		J. H. HARRIS	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
JAN 15 1910		HOSPITAL		DISEASE		SUICIDE		1234	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		SIGNED	
Carpenter		High School		Roman Catholic		Married		J. H. HARRIS	

885

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>3106 Kingtree Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Infant (Newborn)</u> Middle <u>Little</u> Last <u>Little</u>				4. DATE OF DEATH Month <u>January</u> Day <u>28</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 28, 1959</u>	
9. AGE (In years last birthday) yrs. <u>3</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Roy F. Little</u>		14. MOTHER'S MAIDEN NAME <u>Sylvia Belcher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Sylvia Little</u>		Address <u>3106 Kingtree Street Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>761.5 Stibularis</u> DUE TO (b) <u>Prematurity</u> DUE TO (c) <u>Premature Separation placenta.</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Michael L. Buckley</u>				ADDRESS (Street, city or town, state) <u>4630 Montg. Ave. Bethesda, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Michael L. Buckley</u>				DATE SIGNED <u>1/28/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 4 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of deceased
 2. Date of death
 3. Place of death
 4. Cause of death
 5. Age at death
 6. Sex
 7. Race
 8. Marital status
 9. Occupation
 10. Education
 11. Religion
 12. Social status
 13. Family history
 14. Medical history
 15. Mental history
 16. Physical examination
 17. Laboratory tests
 18. Pathological findings
 19. Clinical course
 20. Prognosis
 21. Treatment
 22. Outcome
 23. Signature of physician
 24. Signature of registrar
 25. Date of registration

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
AGE AT DEATH		SEX		RACE	
MARRIAGE		OCCUPATION		EDUCATION	
RELIGION		SOCIAL STATUS		FAMILY HISTORY	
MEDICAL HISTORY		MENTAL HISTORY		PHYSICAL EXAMINATION	
LABORATORY TESTS		PATHOLOGICAL FINDINGS		CLINICAL COURSE	
PROGNOSIS		TREATMENT		OUTCOME	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION	

1 886 Item 2 Film G238 2-2-59 et 00874 Reg. Dist. No.

886 Item 2 Film G238 2-2-59 et 00874 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 9yr. 2mo. 12da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home		d. STREET ADDRESS Methodist Home Route #1	
3. NAME OF DECEASED (Type or print) First Millie Middle Ella Last Little		4. DATE OF DEATH Month January Day 20 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 11, 1863
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR Months 06 Days 27 Hours 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Matron		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Rezin F. Albert		14. MOTHER'S MAIDEN NAME Hannah Backingham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) hypertensive cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 1-19-59
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-4 19 55 to 1-20 19 59 , that I last saw the deceased alive on 1-20 19 59 , and that death occurred at 9:45P M, from the causes and on the date stated above.	
ACTUAL SIGNATURE Sarah E. Glover	ADDRESS (Street, city or town, state) 10128 CEDAR LANE, Kensington Md
PHYSICIAN'S NAME (Type) Sarah E. Glover, M. D.	DATE SIGNED 1-20-59

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/24/59	22c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery	22d. LOCATION (City, town, or county) (State) Westminster, Carroll Md.
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23. FUNERAL DIRECTOR'S SIGNATURE James H. Saffell	ADDRESS 254 E. Main St. Westminster, Md.	24a. REC'D BY REGISTRAR DATE JAN 23 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kneass
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0324

6-11-70

Small 2nd

887

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>4 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>4808 Wellington Dr.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Victor Samuel Little</u>				4. DATE OF DEATH Month Day Year <u>Jan. 19 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 6, 1889</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Automotive</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Little</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Brush</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWI</u>				16. SOCIAL SECURITY NO. <u>578-05-9757</u>			
17. INFORMANT <u>Mary Little</u>				Address <u>4808 Wellington Dr.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arterio sclerosis</u> DUE TO (c) <u>6 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>January 14, 1959</u> to <u>January 19, 1959</u> , that I last saw the deceased alive on <u>January 19, 1959</u> , and that death occurred at <u>7:25 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Charles W. Humphreys, Jr.</u> M.D.				1746 K St. N.W., Wash. D.C.			
PHYSICIAN'S NAME (Type) <u>Charles W. Humphreys, Jr.</u>							
22a. BURIAL CREMATION REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1/22/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.,</u>				40. REC'D BY REGISTRAR DATE <u>JAN 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WESTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

888

CERTIFICATE OF DEATH

Reg. Dist. No.

00876

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>83x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Castell Hall Sanatorium</u>				d. STREET ADDRESS <u>1545 S. Vermont St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>T</u> Last <u>Slloyd</u>				4. DATE OF DEATH Month <u>1</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 7-1879</u> yrs.	
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>3</u>		11. IF UNDER 24 HRS. Hours <u>19</u> Min. <u>59</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				13b. KIND OF BUSINESS OR INDUSTRY <u>Home making</u>			
13. FATHER'S NAME <u>John Wallace</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane McArthur</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Nursing Home Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension with chronic congestive heart failure</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec 27</u> , 19 <u>58</u> , to <u>Jan. 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan. 3</u> , 19 <u>59</u> , and that death occurred at <u>3:30 p. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. Stephen Hulbert</u>				ADDRESS (Street, city or town, state) <u>3000 Pont Place, NW</u>			
PHYSICIAN'S NAME (Type) <u>R. Stephen Hulbert</u>				DATE SIGNED <u>Jan 3, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-6-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. M. Travel</u>				ADDRESS <u>2847 Wilson Blvd. Arlington Va.</u>			
24a. REC'D BY REGISTRAR DATE <u>JAN 7 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

889

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 92 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY 75-X-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Selinsgrove d. STREET ADDRESS 907 North 8th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Karen Sue Luttrell		4. DATE OF DEATH Month Day Year January 3, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1956
9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard P. Luttrell		14. MOTHER'S MAIDEN NAME Phyllis Brinkley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Leukemia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 9 Months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 3, 1958 , to January 3, 1959 , that I last saw the deceased alive on January 3, 1959 , and that death occurred at 6:05 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 1-4-59 National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE Nathan S. Taylor M.D.		PHYSICIAN'S NAME (Type) Nathan S. Taylor, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 1-4-59		22b. DATE THEREOF 1-4-59	
22c. NAME OF CEMETERY OR CREMATORY Lawn Croft Cemetery		22d. LOCATION (City, town, or county) (State) Delaware County, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY,		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE JAN 7 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-102 100-102

775
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY CO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JAN. PARK.				c. LENGTH OF STAY IN 1b WFE.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN + HOSP.				d. STREET ADDRESS 8121 South Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last MACKEY				4. DATE OF DEATH Month Day Year January 28 1959			
5. SEX Boy	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-27-59		9. AGE (In years last birthday) yrs. 1 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Donald Robert Mackay				14. MOTHER'S MAIDEN NAME Faith MacKongie Beltz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATELECTASIS, FETAL TYPE. 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PREMATURITY DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH LIFE. LIFE.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/27 , 19 59 , to 1/28 , 19 59 , that I last saw the deceased alive on 1/28 , 19 59 , and that death occurred at 725 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7309 RIGGS RD. 1/28/59							
ACTUAL SIGNATURE Joseph J. McDonald M.D.				PHYSICIAN'S NAME (Type) W. HYATTSVILLE MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 2-13-59		22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium & Hospital		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert H. Hare, M.D.				ADDRESS Washington Sanitarium & Hospital		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corbor papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		PLACE OF BIRTH <i>New York City</i>	
SEX <i>Male</i>		AGE <i>45</i>	
DATE OF DEATH <i>Jan 15 1924</i>		TIME OF DEATH <i>10:30 AM</i>	
PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>	
DISEASE OR INJURY <i>Myocardial Infarction</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>John Smith</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
DATE OF SIGNATURE <i>Jan 15 1924</i>		DATE OF SIGNATURE <i>Jan 15 1924</i>	

RECEIVED
 JAN 15 1924
 BALTIMORE

890

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>1240 North Washington Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Boy Mahone</u>				4. DATE OF DEATH Month Day Year <u>1 4 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-4-59</u>	9. AGE (In years last birthday) yrs. <u>1</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>4 1 40</u>	IF UNDER 24 HRS. <u>40</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Edgar Mahone</u>				14. MOTHER'S MAIDEN NAME <u>Dean Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Dean Smith, 240 N. Wash. St. Rockville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Failure</u> DUE TO <u>Immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 5, 1959</u> , to <u>Jan 5, 1959</u> , that I last saw the deceased alive on <u>Jan 5, 1959</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas M. Wilson</u> M.D.				ADDRESS (Street, city or town, state) <u>8218 Wisconsin Ave Bethesda, MD</u>			
DATE SIGNED <u>FEB 2 '59</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 7 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Linsden</u> ADDRESS <u>Rockville Md</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Krawe</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00879

891

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Theater</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Theater</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Residence</u>		d. STREET ADDRESS <u>1704 Alberti Road</u>	
3. NAME OF DECEASED (Type or print) First <u>L</u> Middle <u>G</u> Last <u>MANUEL</u>		4. DATE OF DEATH Jan. 4 19 59	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19- 1889</u>
9. AGE (In years lost birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laundrying - Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Said Percy</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Donal E. Manuel</u>		Address <u>1704 Alberti Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> <u>175.0</u> DUE TO <u>adenocarcinoma of ovarian</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. } DUE TO <u>origin</u> (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>58</u> , to <u>Jan 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 4</u> , 19 <u>59</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank L. Williamson</u> M.D.		ADDRESS (Street, city or town, state) <u>2731 Connecticut Ave. Washington D.C.</u>	
DATE SIGNED <u>1/4/59</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 7-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Leo Paul Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>River Road - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>		ADDRESS <u>254 Carroll St. N.E.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hays</u>	
DATE <u>Jan 7 '59</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____	
DATE OF DEATH _____		TIME OF DEATH _____		PLACE OF DEATH _____	
OCCASION OF DEATH _____		CAUSE OF DEATH _____		MANNER OF DEATH _____	
PLACE OF BIRTH _____		DATE OF BIRTH _____		SEX AT BIRTH _____	
OCCUPATION _____		EDUCATION _____		RELIGION _____	
MARITAL STATUS _____		PREVIOUS MARRIAGES _____		PREVIOUS DEATHS _____	
NAME OF PHYSICIAN _____		NAME OF NURSE _____		NAME OF ATTENDING CLERGYMAN _____	
NAME OF FUNERAL HOME _____		NAME OF BURIAL PLACE _____		NAME OF CEMETERY _____	
NAME OF INTERVIEWER _____		NAME OF WITNESS _____		NAME OF SIGNER _____	
NAME OF REGISTRAR _____		NAME OF CLERK _____		NAME OF ASSISTANT CLERK _____	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND.
 IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Department of Health, at Baltimore, Maryland, this _____ day of _____, 19____.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

892

CERTIFICATE OF DEATH

00880

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ 83x-3 d. STREET ADDRESS 807 North Columbus Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Carl Eugene Marks			4. DATE OF DEATH Month Day Year January 7, 1959				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 30, 1958		9. AGE (In years last birthday) yrs. Months Days Hours Min. 4 8		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia			
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Herbert J. Marks				
14. MOTHER'S MAIDEN NAME Elizabeth L. Winston			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. None			17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral severe pulmonary atelectasis & pneumonia 754.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital heart disease, ventricular septal defect DUE TO (c) 4 mos PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 mos					INTERVAL BETWEEN ONSET AND DEATH 2 mos		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 4, 1959 , to January 7, 1959 , that I last saw the deceased alive on January 7, 1959 , and that death occurred at 4:25 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert D. Bloodwell		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 1-8-59			
PHYSICIAN'S NAME (Type) Robert D. Bloodwell, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-10-59		22c. NAME OF CEMETERY OR CREMATORY Bethel			
22d. LOCATION (City, town, or county) (State) Alexandria, Virginia							
23. FUNERAL DIRECTOR'S SIGNATURE Cunningham Funeral Home Inc.		ADDRESS Alexandria, Va.		24. REC'D BY REGISTRAR JAN 12 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. Kline							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

794

CERTIFICATE OF DEATH

Reg. Dist. No.

00881

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE D.C. b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47x-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WAVERLY SANITARIUM			d. STREET ADDRESS Chatham Courts, Columbia Rd., N.W.		
3. NAME OF DECEASED (Type or print) First LOUISE Middle GIDDINGS Last MARTIN			4. DATE OF DEATH Month JAN. Day 17 Year 1959		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/1/66		9. AGE (In years last birthday) 92 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Leesburg, Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Charles Glenville			14. MOTHER'S MAIDEN NAME Dorcas Hempston		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Mrs. John R. Clark, White Oak, Maryland			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 12 hours 8-10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from January 10, 1957 , to January 17, 1959 , that I last saw the deceased alive on January 17, 1959 , and that death occurred at 12:00 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE W.B. Wardrop M.D.			ADDRESS (Street, city or town, state) 837 Bonifant St. Silver Spring Md. DATE SIGNED 1/17/59		
PHYSICIAN'S NAME (Type) W.B. WARDROP M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/20/59		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	
22d. LOCATION (City, town, or county) (State) Washington, D. C.					
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Jiska			ADDRESS SILVER SPRING, MD.		
24a. REC'D BY REGISTRAR JAN 21 '59			24b. REGISTRAR'S SIGNATURE Arthur S. Haus		

776

CERTIFICATE OF DEATH

00882

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>17300 Cedar Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>Mary Walnut McCabe</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-78</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Months <u>17</u> Days <u>17</u> Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>
13. FATHER'S NAME <u>Charles Walnut</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>PT's chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> (c) <u>Arteriosclerotic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u> <u>14 R</u> <u>5 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 10</u> , 19 <u>53</u> to <u>Jan 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/17/59</u> , 19 <u>59</u> , and that death occurred at <u>9:20</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Horace H. Heston</u>				ADDRESS (Street, city or town, state) <u>1852 Columbia Rd NW</u>			
DATE SIGNED <u>1/17/59</u>							
PHYSICIAN'S NAME (Type) <u>Washington 9, DC</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 21, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Philadelphia, Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				ADDRESS <u>254 Carroll St NW DC</u>		24a. REC'D BY REGISTRAR <u>AN 20 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

778

1. NAME OF DECEASED JAMES M. SMITH		2. SEX Male		3. AGE 65	
4. DATE OF DEATH April 15, 1945		5. PLACE OF DEATH Home		6. CITY AND COUNTY Baltimore, Md.	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. SIGNATURE OF PHYSICIAN J. M. Smith	
10. SIGNATURE OF REGISTRAR J. M. Smith		11. SIGNATURE OF WITNESSES J. M. Smith		12. SIGNATURE OF DECEASED J. M. Smith	
13. SIGNATURE OF FUNERAL HOME J. M. Smith		14. SIGNATURE OF BURIAL PLACE J. M. Smith		15. SIGNATURE OF INTERMENT J. M. Smith	
16. SIGNATURE OF CEMETERY J. M. Smith		17. SIGNATURE OF BURIAL PLACE J. M. Smith		18. SIGNATURE OF INTERMENT J. M. Smith	
19. SIGNATURE OF CEMETERY J. M. Smith		20. SIGNATURE OF BURIAL PLACE J. M. Smith		21. SIGNATURE OF INTERMENT J. M. Smith	
22. SIGNATURE OF CEMETERY J. M. Smith		23. SIGNATURE OF BURIAL PLACE J. M. Smith		24. SIGNATURE OF INTERMENT J. M. Smith	
25. SIGNATURE OF CEMETERY J. M. Smith		26. SIGNATURE OF BURIAL PLACE J. M. Smith		27. SIGNATURE OF INTERMENT J. M. Smith	
28. SIGNATURE OF CEMETERY J. M. Smith		29. SIGNATURE OF BURIAL PLACE J. M. Smith		30. SIGNATURE OF INTERMENT J. M. Smith	
31. SIGNATURE OF CEMETERY J. M. Smith		32. SIGNATURE OF BURIAL PLACE J. M. Smith		33. SIGNATURE OF INTERMENT J. M. Smith	
34. SIGNATURE OF CEMETERY J. M. Smith		35. SIGNATURE OF BURIAL PLACE J. M. Smith		36. SIGNATURE OF INTERMENT J. M. Smith	
37. SIGNATURE OF CEMETERY J. M. Smith		38. SIGNATURE OF BURIAL PLACE J. M. Smith		39. SIGNATURE OF INTERMENT J. M. Smith	
40. SIGNATURE OF CEMETERY J. M. Smith		41. SIGNATURE OF BURIAL PLACE J. M. Smith		42. SIGNATURE OF INTERMENT J. M. Smith	
43. SIGNATURE OF CEMETERY J. M. Smith		44. SIGNATURE OF BURIAL PLACE J. M. Smith		45. SIGNATURE OF INTERMENT J. M. Smith	
46. SIGNATURE OF CEMETERY J. M. Smith		47. SIGNATURE OF BURIAL PLACE J. M. Smith		48. SIGNATURE OF INTERMENT J. M. Smith	
49. SIGNATURE OF CEMETERY J. M. Smith		50. SIGNATURE OF BURIAL PLACE J. M. Smith		51. SIGNATURE OF INTERMENT J. M. Smith	
52. SIGNATURE OF CEMETERY J. M. Smith		53. SIGNATURE OF BURIAL PLACE J. M. Smith		54. SIGNATURE OF INTERMENT J. M. Smith	
55. SIGNATURE OF CEMETERY J. M. Smith		56. SIGNATURE OF BURIAL PLACE J. M. Smith		57. SIGNATURE OF INTERMENT J. M. Smith	
58. SIGNATURE OF CEMETERY J. M. Smith		59. SIGNATURE OF BURIAL PLACE J. M. Smith		60. SIGNATURE OF INTERMENT J. M. Smith	
61. SIGNATURE OF CEMETERY J. M. Smith		62. SIGNATURE OF BURIAL PLACE J. M. Smith		63. SIGNATURE OF INTERMENT J. M. Smith	
64. SIGNATURE OF CEMETERY J. M. Smith		65. SIGNATURE OF BURIAL PLACE J. M. Smith		66. SIGNATURE OF INTERMENT J. M. Smith	
67. SIGNATURE OF CEMETERY J. M. Smith		68. SIGNATURE OF BURIAL PLACE J. M. Smith		69. SIGNATURE OF INTERMENT J. M. Smith	
70. SIGNATURE OF CEMETERY J. M. Smith		71. SIGNATURE OF BURIAL PLACE J. M. Smith		72. SIGNATURE OF INTERMENT J. M. Smith	
73. SIGNATURE OF CEMETERY J. M. Smith		74. SIGNATURE OF BURIAL PLACE J. M. Smith		75. SIGNATURE OF INTERMENT J. M. Smith	
76. SIGNATURE OF CEMETERY J. M. Smith		77. SIGNATURE OF BURIAL PLACE J. M. Smith		78. SIGNATURE OF INTERMENT J. M. Smith	
79. SIGNATURE OF CEMETERY J. M. Smith		80. SIGNATURE OF BURIAL PLACE J. M. Smith		81. SIGNATURE OF INTERMENT J. M. Smith	
82. SIGNATURE OF CEMETERY J. M. Smith		83. SIGNATURE OF BURIAL PLACE J. M. Smith		84. SIGNATURE OF INTERMENT J. M. Smith	
85. SIGNATURE OF CEMETERY J. M. Smith		86. SIGNATURE OF BURIAL PLACE J. M. Smith		87. SIGNATURE OF INTERMENT J. M. Smith	
88. SIGNATURE OF CEMETERY J. M. Smith		89. SIGNATURE OF BURIAL PLACE J. M. Smith		90. SIGNATURE OF INTERMENT J. M. Smith	
91. SIGNATURE OF CEMETERY J. M. Smith		92. SIGNATURE OF BURIAL PLACE J. M. Smith		93. SIGNATURE OF INTERMENT J. M. Smith	
94. SIGNATURE OF CEMETERY J. M. Smith		95. SIGNATURE OF BURIAL PLACE J. M. Smith		96. SIGNATURE OF INTERMENT J. M. Smith	
97. SIGNATURE OF CEMETERY J. M. Smith		98. SIGNATURE OF BURIAL PLACE J. M. Smith		99. SIGNATURE OF INTERMENT J. M. Smith	
100. SIGNATURE OF CEMETERY J. M. Smith		101. SIGNATURE OF BURIAL PLACE J. M. Smith		102. SIGNATURE OF INTERMENT J. M. Smith	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

893

CERTIFICATE OF DEATH

00883

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON 47X-3 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL				d. STREET ADDRESS 3426 -16th ST. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last FLORENCE M McKEEVER				4. DATE OF DEATH Month Day Year 1 1 1959			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1876		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ionia, Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Benjamin Franklin Spencer				14. MOTHER'S MAIDEN NAME Sarah Kidd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Margaret M. Brumbaugh		Address 4309 Elm St. Chevy Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF BLADDER						INTERVAL BETWEEN ONSET AND DEATH 7 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1954, to Jan. 1, 1959, that I last saw the deceased alive on January 1, 1959, and that death occurred at 1045 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1673 - PARK Road N.W. Washington D.C. DATE SIGNED							
ACTUAL SIGNATURE James M. Loftus M.D.		PHYSICIAN'S NAME (Type) James M. Loftus					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/3/59		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company ADDRESS Washington, D.C.				24a. REC'D BY REGISTRAR JAN 5 '59 DATE		24b. REGISTRAR'S SIGNATURE William S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00884

894

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY McSherrystown c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ McSherrystown d. STREET ADDRESS 123 2nd Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Grover Last McKinney		4. DATE OF DEATH Month January Day 4 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 19, 1884
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cigar Maker		10b. KIND OF BUSINESS OR INDUSTRY Cigar Manufacturer	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph McKinney		14. MOTHER'S MAIDEN NAME Margaret Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) G. I. Bleeding DUE TO (c) Chronic Lymphatic Leukemia INTERVAL BETWEEN ONSET AND DEATH 12 d 2 d 8 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1, 1959 to January 4, 1959 , that I last saw the deceased alive on January 4, 1959 , and that death occurred at 2:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/5/59			
ACTUAL SIGNATURE James M. Marsh M.D.		DATE SIGNED 1/5/59	
PHYSICIAN'S NAME (Type) James M. Marsh, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried Jan 8 1959 St Mary		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) McSherrystown Adams Pm	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Gernem		ADDRESS McSherrystown Pm	
24a. REC'D BY REGISTRAR JAN 13 '59		24b. REGISTRAR'S SIGNATURE Carlton S. Hume	

CERTIFICATE OF DEATH

386

DATE

REGISTRATION

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

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INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00885

895

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Montgomery		STATE Maryland		COUNTY Montgomery			
CITY (If outside corporate limits, write RURAL and give nearest town) Ashton		LENGTH OF STAY (in this place) 4 Days		CITY (If outside corporate limits, write RURAL and give nearest town) Gaithersburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Belmont Nursing Home		STREET ADDRESS (If rural give location) R.F.D. 2					
3. NAME OF DECEASED (First) (Middle) (Last) John Edward McMahon				4. DATE OF DEATH (Month) (Day) (Year) Jan. 2 1959			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct. 21 1871	9. AGE last birthday 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John E. McMahon				14. MOTHER'S MAIDEN NAME Valeria Pugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 217 03 7699		17. INFORMANT & ADDRESS Mabel Arnold Same As 2			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
446X IMMEDIATE CAUSE (A) Chronic Nephritis						INTERVAL BETWEEN ONSET AND DEATH years	
ANTECEDENT CAUSE(S) DUE TO (B) Atherosclerosis						years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Urasmia						5 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/29/58, 1958, to 1/2/59, 1959, that I last saw the deceased alive on 12/27, 1958, and that death occurred at 11:27 A.M. from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>				ADDRESS (Street, city, town, state) <i>[Address]</i>		DATE SIGNED <i>[Date]</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan. 6 1959		NAME OF CEMETERY OR CREMATORY Forrest Oak		LOCATION (City, town, or county) (State) Gaithersburg Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		ADDRESS Laytonsville, Md.	
DATE JAN 7 '59							

CERTIFICATE OF DEATH

Reg. Dist. No.

LOCAL HEALTH OFFICE NUMBER (LOCAL 1945)

PLACE OF DEATH

NAME OF DECEASED

MARYLAND

DATE OF DEATH

TIME OF DEATH

AGE OF DECEASED

SEX OF DECEASED

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

DATE OF DEATH

TIME OF DEATH

AGE OF DECEASED

SEX OF DECEASED

CAUSE OF DEATH

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Items 20b&c Film 237 1-16-59 am

895

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>			d. STREET ADDRESS <u>1610 Park Road N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Margaret Theresa McPhee</u>			4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1959</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25 1874</u>		9. AGE (In years last birthday) <u>84</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>buyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing Industry</u>		11. BIRTHPLACE (State or foreign country) <u>Maine</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>Daniel McPhee</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>578-07-0835A</u>		17. INFORMANT <u>Delia E. Hessian, 1610 Park Road N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO (b) <u>Fracture of left hip following</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>operative procedure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>6 days</u> <u>1 hr.</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fallen on floor after entering Woodward & Lothrop's downtown store, D.C.</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>3</u> a.m. <u>12-30</u> 1958 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hotel Store Washington D.C.</u>	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1-5-59</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		22b. DATE THEREOF <u>1/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Portland, Maine</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>			24a. REC'D BY REGISTRAR <u>JAN 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH

11-1-1918

11-1-1918

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL EXAMINER'S SIGNATURE		DATE OF EXAMINATION		PLACE OF EXAMINATION	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00887

795

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor Sanatorium</u>				d. STREET ADDRESS <u>3708 16th St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Herman</u> Last <u>Meyers</u>				4. DATE OF DEATH Month <u>1</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/4/1876</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months <u>2</u> Days <u>27</u>		Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Deenymen</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Herman Meyers</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Aldenberg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-032438</u>		17. INFORMANT <u>Mrs. John Meyers</u> Address <u>3939 Washington St. Washington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Thrombosis & Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 7.</u> Month <u>19</u> Day <u>19</u> Year <u>1959</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>29 Jan</u> , 19 <u>59</u> , to <u>Jan 29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>29 Jan</u> , 19 <u>59</u> , and that death occurred at <u>5:55 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>809 Viershull Rd.</u> DATE SIGNED <u></u>							
ACTUAL SIGNATURE <u>Herman C. Chaparain</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Herman C. Chaparain</u>				<u>Rockville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>	

897

CERTIFICATE OF DEATH

Reg. Dist. No.

00888

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 733 Jefferson Street, N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George Ernest Milburn, III				4. DATE OF DEATH Month Day Year January 15, 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 27, 1948	
9. AGE (In years last birthday) 10		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) District of Columbia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George E. Milburn, Jr.				14. MOTHER'S MAIDEN NAME Gertrude Rivkin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tumor of the Midbrain 237X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from January 13, 1959 , to January 15, 1959 , that I last saw the deceased alive on January 15, 1959 , and that death occurred at 5:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 1/15/59 ACTUAL SIGNATURE Charles A. Buckman M.D. The Clinical Center NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland PHYSICIAN'S NAME (Type) Charles A. Buckman, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 1/16/59		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WAGNER E. PUMPHREY, INC. Raymond A. Ziska				24a. REC'D BY REGISTRAR DATE JAN 19 59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

898

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>102 Univ. Blvd. East</u>				d. STREET ADDRESS <u>102 Univ. Blvd. East</u>			
3. NAME OF DECEASED (Type or print) First <u>ZOA</u> Middle <u>Elizabeth</u> Last <u>Milner</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 2 1893</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Auburn, N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Pittchley</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT (Daughter) <u>Mrs. George Beall Jr.</u>				Address <u>102 Univ. Blvd. East Silver Spring</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 3</u> , 19 <u>59</u> , to <u>Jan 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 3</u> , 19 <u>59</u> , and that death occurred at <u>9:42</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Marion Bankhead</u> M.D.				ADDRESS (Street, city or town, state) <u>9241 Col. Blvd</u>			
DATE SIGNED <u>1/4/59</u>							
PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u>				Address <u>Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-7-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WASH</u>		22d. LOCATION (City, town, or county) (State) <u>WATERTVILLE, N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hysong</u> ADDRESS <u>1300-N ST. N.W., D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thane</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

00894

899

1. PLACE OF DEATH o. COUNTY <i>Montg</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>DC</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington 47x-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rest Mor Sam</i>		d. STREET ADDRESS <i>6301-16th St. NW</i>	
3. NAME OF DECEASED (Type or print) <i>Mollie</i> First <i>Moldauer</i> Middle <i>Moldauer</i> Last		4. DATE OF DEATH <i>Jan 6-1959</i> Month <i>Jan</i> Day <i>6</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 6-1895</i>
9. AGE (In years last birthday) <i>63</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>USA-</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Max HARRIS</i>		14. MOTHER'S MAIDEN NAME <i>Fannie SHERBY</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>599-10-5911</i>	
17. INFORMANT <i>Leonard Moldauer</i> Address <i>4504-AVAMERE ST. Bethesda</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatous</i> <i>180x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma of R. ureter</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> <i>Feb 1956</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Feb.</i> , 19 <i>56</i> , to <i>Jan 6</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Jan. 5</i> , 19 <i>59</i> , and that death occurred at <i>7:30 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Samuel Dessoff</i> M.D.		ADDRESS (Street, city or town, state) <i>1302-18th St. NW Wash DC</i>	
DATE SIGNED <i>1/6/59</i>			
PHYSICIAN'S NAME (Type) <i>SAMUEL DESSOFF</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>1/8/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Adas Israel Cem DC</i>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home</i>		ADDRESS <i>4217-9th St NW</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
DATE <i>JAN 8 '59</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

300

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9502 Saybrook Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>Albert</u> Middle <u>Moore</u> Last		4. DATE OF DEATH <u>January</u> Month <u>17</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>May 2, 1909</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac J. Moore</u>		14. MOTHER'S MAIDEN NAME <u>Susan Miles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-03-8778</u>	
17. INFORMANT <u>Mrs. Bessie Schrider</u>		Address <u>Silver Spring, Md. 9502 Saybrook Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral and pulmonary edema</u> <u>260x</u> DUE TO <u>Chronic glomerular nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(intercapillary glomerulonephritis)</u> DUE TO (c) <u>Diabetes mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>19 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>Jan 17 1959</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 20, 1940</u> , to <u>Jan. 17, 1959</u> , that I last saw the deceased alive on <u>Jan. 17, 1959</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. Clarence Rice</u> M.D.		ADDRESS (Street, city or town, state) <u>1150 Connecticut Ave. N.W.</u> DATE SIGNED <u>1/17/59</u>	
PHYSICIAN'S NAME (Type) <u>E. CLARENCE RICE</u>		<u>Washington 6, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/20/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BURTONSVILLE UNION CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>Raymond A. Ziska</u> DATE <u>JAN 21 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

901

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairland		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairland Nursing Home		d. STREET ADDRESS 13801 Colesville Road	
3. NAME OF DECEASED (Type or print) First William M. Middle Moore Last		4. DATE OF DEATH Month 1 Day 12 Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY Grocery	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Frank Moore		14. MOTHER'S MAIDEN NAME Lucia Ball	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		17. INFORMANT Carl Moore Address 422 Eisner St. Sil. Sp., Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from December 31, 1958 , to January 12, 1959 , that I last saw the deceased alive on January 11, 1959 , and that death occurred at 3:35 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Boris Rabkin		DATE SIGNED 1/12/59	
PHYSICIAN'S NAME (Type) Boris Rabkin, M.D.		ADDRESS (Street, city or town, state) 1019 University Blvd. Silver Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/14/59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland Md
23. FUNERAL DIRECTOR'S SIGNATURE J. Wm. Lee's Sons Co. 300-4th St. N.E. Wash		24a. REC'D BY REGISTRAR DATE 2 JAN 6 59	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>	
<p>2. Age: <u>45</u> years</p>	
<p>3. Sex: <u>Male</u></p>	
<p>4. Date of death: <u>May 10, 1910</u></p>	
<p>5. Place of death: <u>At home</u></p>	
<p>6. Cause of death: <u>Heart disease</u></p>	
<p>7. Signature of physician: <u>Dr. J. H. Smith</u></p>	
<p>8. Signature of registrar: <u>W. H. Jones</u></p>	
<p>9. Date of registration: <u>May 12, 1910</u></p>	
<p>10. Place of registration: <u>Boston</u></p>	
<p>11. Name of informant: <u>John J. Brown</u></p>	
<p>12. Address of informant: <u>123 Main St.</u></p>	
<p>13. Signature of informant: <u>John J. Brown</u></p>	
<p>14. Date of completion: <u>May 12, 1910</u></p>	
<p>15. Place of completion: <u>Boston</u></p>	

CERTIFICATE OF DEATH

Reg. Dist. No.

902

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D. of C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>10 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>2316 Tunlaw Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>L</u> Last <u>Moose</u>				4. DATE OF DEATH Month <u>January</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 29, 1919</u>	
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William E. Large here</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Barney T.V. Moose</u>		Address <u>2316 Tunlaw Road, Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Marked cerebral edema</u> <u>1930</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>intracerebral hemorrhage</u> (c) <u>ischemic of an old parieto-occipital lobe</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1959</u> Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1-21</u> , 19 <u>57</u> to <u>1-21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-21</u> , 19 <u>59</u> , and that death occurred at <u>3A</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J.P. Murphy</u>				ADDRESS (Street, city or town, state) <u>1904 R. J. h. w. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>J.P. MURPHY</u>				DATE SIGNED <u>1-21-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 24, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Myer Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fort Myer, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Binchossens</u>				ADDRESS <u>3034 17th St NW</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 23 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CORNER NOTIFIED

CERTIFICATE OF DEATH

STATE OF MICHIGAN - BUREAU OF HEALTH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

EDUCATION

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

REMARKS

DATE OF DEATH

1. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above.

2. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above.

3. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above.

4. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above.

5. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above.

6. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above.

7. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above.

8. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above.

9. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above.

10. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above.

11. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above.

12. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above.

13. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above.

14. I hereby certify that the above is a true and correct statement of the facts as to the death of the person named above.

903

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <i>Mont</i> Maryland MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 44 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Albert Last MORLOCK				4. DATE OF DEATH Month January Day 23 Year 19 59			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-15-93	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service				10b. KIND OF BUSINESS OR INDUSTRY U.S.State Dept.		11. BIRTHPLACE (State or foreign country) Mass.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Peter A. Morlock				14. MOTHER'S MAIDEN NAME Emily Root			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WWI				16. SOCIAL SECURITY NO. None			
17. INFORMANT (W) Mrs. Ethel B. Morlock, same as #2 above				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bethesda				20g. (County) Montgomery		20h. (State) Md.	
21. I certify that I attended the deceased from December 10, 19 59 , to January 23, 19 59 , that I last saw the deceased alive on January 22, 19 59 , and that death occurred at 2:20A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. G. Muth				DATE SIGNED 1-23-59			
PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN				ADDRESS (Street, city or town, state) Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-27-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey Funeral Home, Bethesda, Md.				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR JAN 27 59	
				24b. REGISTRAR'S SIGNATURE John S. K...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1903

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Burial Officer

Signature of Minister

Signature of Undertaker

Signature of Family

Signature of Friends

Signature of Neighbors

Signature of Community

Signature of Church

Signature of Society

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

904

CERTIFICATE OF DEATH

00895

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>3 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11924 ANDREW COURT</u>				d. STREET ADDRESS <u>11924 ANDREW COURT</u>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>E.</u> Last <u>MURPHY</u>				4. DATE OF DEATH Month <u>1</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-29-89</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AUTOMOBILE SERVICE</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WILLIAM MURPHY</u>				14. MOTHER'S MAIDEN NAME <u>KATHRYN SOURBIER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-42-192</u>		17. INFORMANT <u>DOROTHY M. GILLER</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>8 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>3/10/1957</u> , to <u>1/21/1959</u> , that I last saw the deceased alive on <u>1/21/1959</u> , and that death occurred at <u>9 A.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John J. Curry</u> M.D.				ADDRESS (Street, city or town, state) <u>10620 Georgia Ave Silver Spring, Md</u>			
DATE SIGNED <u>1/21/59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>				ADDRESS <u>3821 14th. N.W.</u>		24a. REC'D BY REGISTRAR <u>JAN 23 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Robert B. Purnell</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
JAMES J. GORTY		45		M		W		1880		1925		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM		BURIAL		FUNERAL		INTERMENT	
LABORER		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN IN CHEST		NO		NO		CATHOLIC		CATHOLIC		CATHOLIC	
DATE OF INTERVIEW		INTERVIEWED BY		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER	
JAN 10 1925		J. J. GORTY		J. J. GORTY		J. J. GORTY		J. J. GORTY		J. J. GORTY		J. J. GORTY		J. J. GORTY		J. J. GORTY		J. J. GORTY	

ATTEST

1-23-25
COLUMBIA GARDENS
BALTIMORE, MARYLAND
JAMES J. GORTY

905

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 17 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington, D. C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 3734 Foote Street, N. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Fred Middle Henry Last Nevils				4. DATE OF DEATH Month January Day 24 Year 1959			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 20, 1896	
9. AGE (In years last birthday) 62 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Nevils				14. MOTHER'S MAIDEN NAME Hattie Thompkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 124-07-1164		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterial & arteriolar Nephrosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac hypertrophy, Ascites, Chronic serositis, - peritoneum							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 7, 1959 , to January 24, 1959 , that I last saw the deceased alive on January 24, 1959 , and that death occurred at 10:25 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Guy O. Barnett M.D.				ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 1-24-59	
PHYSICIAN'S NAME (Type) Guy O. Barnett, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Jan 30 1959		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery		22d. LOCATION (City, town, or county) Smithland (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Spazler's Funeral Home				ADDRESS 389 R I Ave NE		24a. REC'D BY REGISTRAR JAN 28 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

20

100

906
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C. 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) 8504 Rayburn Rd.		d. STREET ADDRESS 7530 12th St. N.W.	
3. NAME OF DECEASED (Type or print) ANNIE First Norfleet Middle Norfleet Last		4. DATE OF DEATH Month Jan Day 14 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/23/78
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Martinsville, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Harden Pedigo		14. MOTHER'S MAIDEN NAME Elanor Davison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 151X	
17. INFORMANT Elanor Campbell same as #1		Address #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Carcinomatosis 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adeno carcinoma of Stomach DUE TO (c) 1 yr		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 1948 to Jan 14, 1959 , that I last saw the deceased alive on Jan 14, 1959 , and that death occurred at 0:30 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE E. Herbert Bauersfeld M.D.		ADDRESS (Street, city or town, state) 1912 R St NW DATE SIGNED 1/14/59	
PHYSICIAN'S NAME (Type) E. Herbert Bauersfeld		Washington D.C.	
22a. BURIAL—CREMATION REMOVAL (Specify) burial	22b. DATE THEREOF 1/16/59	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Martinsville, Va.
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Hume Co		24a. REC'D BY REGISTRAR W. H. Hume Co	24b. REGISTRAR'S SIGNATURE Arthur S. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

907

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sanitarium, 3006 McComas Ave.		d. STREET ADDRESS #3 Valley Park Valley Rd.	
3. NAME OF DECEASED (Type or print) First Daniel Middle O'Connell Last O'Connell		4. DATE OF DEATH Month Jan. Day 21 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-24-78
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel O'Connell		14. MOTHER'S MAIDEN NAME Bridget Fealy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -	
17. INFORMANT Joseph D. O'Connell		Address #3 Park Valley Road Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Insufficiency (Uremia) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify, that I attended the deceased from June 19 48 to January 19 59 , that I last saw the deceased alive on Jan 20 19 59 , and that death occurred at 1:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Bernard A. Fitzgerald		DATE SIGNED 1-21-59	
PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD		Address 217 University Blvd E Silver Spring, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-24-59	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS 3821-14th St. N.W. WashDC	
24a. REC'D BY REGISTRAR JAN 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

908

Reg. Disf. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mmty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>17 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2713 Colston Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles Joseph Parrott</u>				4. DATE OF DEATH <u>1-3-1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-15-08</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cable splicer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>P.E.P. Co.</u>			
11. BIRTHPLACE (State or foreign country) <u>Wash. DC</u>				12. CITIZEN OF WHAT COUNTRY? <u>U-S-C</u>			
13. FATHER'S NAME <u>George Parrott</u>				14. MOTHER'S MAIDEN NAME <u>Susan Walsh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>577-09-6051</u>			
17. INFORMANT <u>Virginia Parrott (wife)</u>				Address <u>Item 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>353.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Laryngeal Obstruction</u> (c) <u>Hemorrhage into tongue</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(d) Epilepsy</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>M</u> <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Bruschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BRUSCHANT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 7, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Saffell</u>				24a. REC'D BY REGISTRAR <u>6 '59</u>			
ADDRESS <u>475 HSt, NW</u>				24b. REGISTRAR'S SIGNATURE <u>J. J. Saffell</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH-BUREAU ONE
LOCAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible text and markings on the form, including what appears to be a signature and various checkboxes.]

909

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4720 South Chelsea Lane</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H.</u> Last <u>Pattison</u>				4. DATE OF DEATH Month <u>1</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 3, 1896</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>28</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Talent Lawyer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Allen S. Pattison</u>				14. MOTHER'S MAIDEN NAME <u>Bra L. Hoffman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or date of service) <u>May W.W.I.</u>				16. SOCIAL SECURITY NO. <u>213-38-1408</u>		17. INFORMANT Address <u>Son - William Pattison Jr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Peritonitis, Colon Fistula</u> 153.8 DUE TO <u>RESECTION CA OF COLON</u> 16 DAYS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ADENOCARCINOMA, COLON #</u> 2 YRS (c) <u>MULTIPLE POLYPS COLON</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MULTIPLE POLYPS COLON</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December, 1957</u> to <u>Jan 31</u> , 1959, that I last saw the deceased alive on <u>Jan 31</u> , 1959, and that death occurred at <u>8:40 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5009 Del Ray, Bethesda</u> DATE SIGNED <u>2/11/59</u> ACTUAL SIGNATURE <u>Robert G. Angle</u> M.D. <u>5009 Del Ray, Bethesda</u> PHYSICIAN'S NAME (Type) <u>ROBERT G. ANGLE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-4-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

210

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett Park		c. LENGTH OF STAY IN IL 2 yrs.		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11018 Montrose Avenue				d. STREET ADDRESS 1108 Montrose Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN FRED PETERSON		First		Middle		Last	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Jan. 7, 1959	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 8 Days 1 Hours Min. 		11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer - Retired		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Louis Peterson				14. MOTHER'S MAIDEN NAME Charlotte ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Jennie A. Peterson - Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary infection (Probably Viral) 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Perforation 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-29 , 19 57 , to 1-7 , 19 59 , that I last saw the deceased alive on 1-7- , 19 59 , and that death occurred at 2:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Dr. Morris Perry - 11602 Georgia Ave., Silver Spring, Md. 1/7/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/9/59		22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE JAN 12 1959		24b. REGISTRAR'S SIGNATURE Carlton A. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Primary infection (Gonorrhea) in men

777

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eventide Nursing Home		d. STREET ADDRESS 1651 Newton Street, N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARIE Middle PINK Last HAM		4. DATE OF DEATH Month 1 Day 17 Year 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown 9. AGE (In years last birthday) 88 ? yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no 17. INFORMANT Address Nursing home records (no other available)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Artery Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH @ 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb , 19 56 , to January , 19 59 , that I last saw the deceased alive on January 16 , 19 59 , and that death occurred at 4 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Bernard A. Fitzgerald M.D. 217 University Bldg E. DATE SIGNED 1-17-59		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 1-20-1959	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawley's Son. 1756 Penna. ave N.W. ADDRESS Wash. D.C.		24a. REC'D BY REGISTRAR DATE JAN 20 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00903

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>9 1/2 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Albion Piper</u>		4. DATE OF DEATH <u>Jan. 26 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-5-98</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney - Dept of Agric U. S. Gov't.</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>	
13. FATHER'S NAME <u>Jesse F. Piper</u>		14. MOTHER'S MAIDEN NAME <u>Annabell Stillwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>508-09-8547</u>	
17. INFORMANT <u>med. records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Emphysema of Lungs</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>terminal circulatory failure</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u> <u>8 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1939</u> , 19 <u>59</u> , to <u>Jan 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1026</u> , 19 <u>59</u> , and that death occurred at <u>9:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Kenneth F. Laughlin</u>		DATE SIGNED <u>Jan 26 1959</u>	
PHYSICIAN'S NAME (Type) <u>KENNETH F. LAUGHLIN</u>		ADDRESS <u>934 Edsall St. Silver Spring Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/29/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR <u>JAN 29 '59</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Frank</u>	

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911

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>2703 Munson Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ira Lee Plummer</u>		First Middle Last		4. DATE OF DEATH <u>January 8 1959</u>		Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 22, 1887</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Louis Plummer</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Loomis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>472-14-7799</u>		17. INFORMANT Address <u>The Medical Record The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforation of Stomach</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Peptic Ulceration</u> DUE TO (c) <u>?</u> INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u> <u>? 20 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>lymphoma of bowel & liver & lung metastases</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>December 30 1958</u> , to <u>January 8 1959</u> , that I last saw the deceased alive on <u>January 8 1959</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold R. Silberman</u> M.D.		ADDRESS (Street, city or town, state) <u>The Clinical Center Bethesda 14, Maryland</u>		DATE SIGNED <u>1-9-59</u>			
PHYSICIAN'S NAME (Type) <u>Harold R. Silberman, M. D.</u>		National Institutes of Health Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chung Chao Tzong Hone</u>		ADDRESS <u>5103 Wisconsin St</u>		24a. REC'D BY REGISTRAR <u>DATE 1 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Form with multiple lines for text entry, including fields for name, date, and location. The form is oriented vertically on the page.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00779

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Urbey</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Gaithersburg (rural)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>monty. Co. Gen Hosp</u>		d. STREET ADDRESS <u>R-1</u>	
3. NAME OF DECEASED (Type or print) <u>Sylvia N. Blummer</u>		4. DATE OF DEATH Month <u>1</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-14-58</u>
9. AGE (In years last birthday) <u>1</u> yrs. <u>9</u> Months <u>28</u> Days <u>28</u> Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>	
13. FATHER'S NAME <u>John Blummer</u>		14. MOTHER'S MAIDEN NAME <u>Emma Neal</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>John Blummer (father)</u> Address <u>Stm 2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Bloeschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BLOESCHERT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/14/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Rose</u>		22d. LOCATION (City, town, or county) (State) <u>Cloppers, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sumner</u> ADDRESS <u>Rookville, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 16 '59</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>		DATE <u>1-12-59</u>	

2074234XV4

912

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>68 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 3,</u> <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>1114 E Street, SE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>(None)</u> Last <u>Potter</u>				4. DATE OF DEATH Month <u>January</u> Day <u>25</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 February 1887</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dry Cleaning Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dry Cleaning</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Stephen Season Potter</u>				14. MOTHER'S MAIDEN NAME <u>Mattie Gilbert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-50-8222</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobular Pneumonia</u> <u>502.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Bronchitis + Chronic Pulmonary Fibrosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hodgkin's Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>1 1/2 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 18, 19 58</u> , to <u>January 25, 19 59</u> , that I last saw the deceased alive on <u>January 25, 19 59</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Nathan S. Taylor</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>		DATE SIGNED <u>1-25-59</u>	
PHYSICIAN'S NAME (Type) <u>Nathan S. Taylor, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-28-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamber & Inc. 517-11th St. N.E.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

913

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 52 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				d. STREET ADDRESS BONIFANT ROAD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT I. POWELL				4. DATE OF DEATH Month Day Year JANUARY 7 19 59			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/16/92	
9. AGE (In years last birthday) 66		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME WILLIAM POWELL				14. MOTHER'S MAIDEN NAME IDA --			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS Address OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) Coronary insufficiency DUE TO (c) Hypertensive Cardio Vascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema of lungs.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Jan 5, 1959, to Jan 7, 1959, that I lost saw the deceased olive on Jan 6, 1959, and that death occurred at 4:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE A. D. Bonifant M.D. Sandy Spring, Md 1/7/59 PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D. SANDY SPRING, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Type)		22b. DATE THEREOF 1/10/59		22c. NAME OF CEMETERY OR CREMATORY Bush Park,		22d. LOCATION (City, town, or county) (State) Cooksville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sumner				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE JAN 12 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Huns			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

233

DECEASED

NAME

AGE

SEX

RESIDENCE

DATE

TIME

PLACE

CAUSE

PLACE

DATE

TIME

BY

DATE

TIME

DECEASED

NAME

AGE

SEX

DECEASED

NAME

AGE

RESIDENCE

DATE

CAUSE

PLACE

DATE

TIME

PLACE

DECEASED

NAME

AGE

SEX

RESIDENCE

DATE

TIME

PLACE

CAUSE

PLACE

DATE

TIME

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	c. LENGTH OF STAY IN 1b <u>8 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>525 Bonifant Rd - R-1</u>		d. STREET ADDRESS <u>525 Bonifant Rd - R-1</u>	
3. NAME OF DECEASED (Type or print) <u>Kate OLIVIA Pries</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>fs</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/8/68</u>
9. AGE (In years last birthday) <u>90 yrs.</u>		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Urban</u>		14. MOTHER'S MAIDEN NAME <u>Mary Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Harold Pries (son)</u>		Address <u>Ithaca 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		22b. DATE THEREOF <u>1/11/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Conestoga, Lancaster County, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Zucka</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>JAN 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

HEALTH DATA

DATE OF BIRTH
DATE OF DEATH
PLACE OF BIRTH
PLACE OF DEATH
OCCUPATION
RELIGION
EDUCATION
MARRIAGE
CHILDREN
SIBLINGS
PARENTS
GRANDPARENTS
OTHER RELATIVES
SOCIAL HISTORY
HISTORY OF ILLNESS
PHYSICAL EXAMINATION
LABORATORY TESTS
TREATMENT
DISPOSITION
FOLLOW-UP

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

OCCUPATION

RELIGION

EDUCATION

MARRIAGE

CHILDREN

SIBLINGS

PARENTS

GRANDPARENTS

OTHER RELATIVES

SOCIAL HISTORY

HISTORY OF ILLNESS

PHYSICAL EXAMINATION

LABORATORY TESTS

TREATMENT

DISPOSITION

FOLLOW-UP

CERTIFICATE OF DEATH

00908

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>75 Washington Sanitarium & Hospital</i>		e. STREET ADDRESS <i>3706 Myers Mill Rd</i>	
3. NAME OF DECEASED (Type or print) <i>Edna</i> First <i>Cecelia</i> Middle <i>Raney</i> Last		4. DATE OF DEATH <i>1-21-1959</i> Month <i>1</i> Day <i>21</i> Year <i>1959</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-24-97</i>
9. AGE (In years last birthday) <i>61</i> yrs.		IF UNDER 1 YEAR: Months <i>6</i> Days <i>1</i> Hours <i>1</i> Min.	IF UNDER 24 HRS. Months <i>6</i> Days <i>1</i> Hours <i>1</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hairdresser</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>D. C.</i>	11. BIRTHPLACE (State or foreign country) <i>D. C.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Chas E. Kendra</i>	
14. MOTHER'S MAIDEN NAME <i>Charlotte C. Hazel</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Washington Sanitarium & Hospital</i> Address <i>Park</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Mitastatic Cervical carcinoma obstructive & plaque</i> DUE TO <i>4 trocha & trachea</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>2 weeks -</i> (b) <i>Mitastatic carcinoma of lungs & pleura</i> DUE TO <i>primary and metastatic + 16 days -</i> (c) <i>Carcinoma of breast</i> <i>5 years -</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks -</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Massive Mitastatic Carcinoma of Cervix & uterine body</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Tamoxifen 13, perineal</i>	
20c. TIME OF INJURY Month <i>Jan</i> , Day <i>19</i> , Year <i>1959</i> Hour <i>a. m.</i> <i>p. m.</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan. 19, 1959</i> , to <i>Jan. 21, 1959</i> , that I last saw the deceased alive on <i>Jan. 19, 1959</i> , and that death occurred at <i>10:30 A.M.</i> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <i>7600 Carroll Ave - Washington, D.C.</i>		DATE SIGNED <i>1/21/59</i>	
ACTUAL SIGNATURE <i>John F. Brownberger</i>		PHYSICIAN'S NAME (Type) <i>John F. Brownberger</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-24-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Rood</i>	22d. LOCATION (City, town, or county) (State) <i>Washington, D. C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey</i> ADDRESS <i>7557 White Oak Rd</i>		24a. REC'D BY REGISTRAR <i>DATE 23 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. ADDRESS OF DECEASED</p>		<p>14. ADDRESS OF PHYSICIAN</p>	
<p>15. ADDRESS OF REGISTRAR</p>		<p>16. ADDRESS OF WITNESSES</p>	
<p>17. ADDRESS OF FUNERAL HOME</p>		<p>18. ADDRESS OF BURIAL PLACE</p>	
<p>19. ADDRESS OF INTERMENT</p>		<p>20. ADDRESS OF CREMATION</p>	
<p>21. ADDRESS OF REINTERMENT</p>		<p>22. ADDRESS OF REINTERMENT</p>	
<p>23. ADDRESS OF REINTERMENT</p>		<p>24. ADDRESS OF REINTERMENT</p>	
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<p>99. ADDRESS OF REINTERMENT</p>		<p>100. ADDRESS OF REINTERMENT</p>	

780
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>J</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethel Park</u> 75x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp.</u>				d. STREET ADDRESS <u>2626 Milford Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Della</u> Middle <u>Rae</u> Last <u>Ranson</u>				4. DATE OF DEATH Month <u>1</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-7-83</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswt.</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>William Nichol</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Neff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Niece - Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Congestive Failure - Cardiac</u> (c) <u>Terminal</u>						INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan. 3</u> , 19 <u>59</u> , to <u>Jan. 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan. 13</u> , 19 <u>59</u> , and that death occurred at <u>6:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A Hare</u>				ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u>		DATE SIGNED <u>1/14/59</u>	
PHYSICIAN'S NAME (Type) <u>Robert A Hare, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-15-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Corn</u>		22d. LOCATION (City, town, or county) (State) <u>Sh. Clainville, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u>				ADDRESS <u>4812 Gt. Ave. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 21 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Christina S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED (Print name in full)		2. SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	
3. AGE (In years, months, and days)		4. RACE (Print race)	
5. PLACE OF BIRTH (Print place)		6. DATE OF BIRTH (Print date)	
7. PLACE OF DEATH (Print place)		8. DATE OF DEATH (Print date)	
9. TIME OF DEATH (Print time)		10. CAUSE OF DEATH (Print cause)	
11. MANNER OF DEATH (Print manner)		12. SIGNATURE OF DECEASED (Print signature)	
13. SIGNATURE OF WITNESS (Print signature)		14. SIGNATURE OF DECEASED (Print signature)	
15. SIGNATURE OF WITNESS (Print signature)		16. SIGNATURE OF DECEASED (Print signature)	
17. SIGNATURE OF WITNESS (Print signature)		18. SIGNATURE OF DECEASED (Print signature)	
19. SIGNATURE OF WITNESS (Print signature)		20. SIGNATURE OF DECEASED (Print signature)	
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FOR OFFICIAL USE ONLY
 THIS SECTION IS FOR THE OFFICIAL USE OF THE DEPARTMENT OF HEALTH
 AND IS NOT TO BE FURNISHED TO THE PUBLIC
 IT IS THE POLICY OF THE DEPARTMENT OF HEALTH
 TO MAINTAIN THE CONFIDENTIALITY OF THE INFORMATION
 CONTAINED HEREIN
 ANY DISCLOSURE OF THIS INFORMATION
 TO THE PUBLIC IS PROHIBITED
 BY THE MARYLAND DEPARTMENT OF HEALTH
 AND HUMAN RESOURCES
 REGULATIONS
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00910

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director or, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 4 mo. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) National Institute of Health		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE California b. COUNTY Los Angeles 27 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 X - 3 d. STREET ADDRESS 4619 Ambrose Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Earl Joseph Rasico First Middle Last		4. DATE OF DEATH Jan. 29, 1959 Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/29/1896 9. AGE (In years last birthday) 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales manager		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11. BIRTHPLACE (State or foreign country) Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis X Rasico		14. MOTHER'S MAIDEN NAME Cora Stark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hosp. Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hemorrhage (rt.) 903.7 DUE TO Unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Unknown DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aplastic anemia			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No history. Probably fell in hosp. room	
20c. TIME OF INJURY Month, Day, Year ? a.m. ? 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hosp.		20f. (City or town) (County) (State) Bethesda Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 1/29/59	
EXAMINER'S NAME (Type) Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 1/30/59		22b. DATE THEREOF 1/30/59	
22c. NAME OF CEMETERY OR CREMATORY Los Angeles		22d. LOCATION (City, town, or county) (State) Los Angeles, California	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR JAN 30 '59	
ADDRESS Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

STATE OF TEXAS,
COUNTY OF _____

00911

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				d. STREET ADDRESS <u>19700 Merwood Lane</u>			
3. NAME OF DECEASED (Type or print) <u>Ruth</u> First <u>WAVEN</u> Middle <u>RED</u> Last <u>MILES</u>				4. DATE OF DEATH Month <u>1</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-18-1898</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWF.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>							
13. FATHER'S NAME <u>JAMES Pumphrey</u>				14. MOTHER'S MAIDEN NAME <u>Lydia Reed</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT Address <u>Hospital Record.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion Acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERIOSCLEROSIS</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Jan 22</u> , 19 <u>59</u> , to <u>Jan 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 25</u> , 19 <u>59</u> , and that death occurred at <u>4:41</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Bernard A. Fitzgerald</u> M.D. <u>217 University Blvd E</u> <u>1-26-59</u> PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u> <u>Silver Spring Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>TRINITY CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>UPPER MARLBORO, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pumphrey, Inc.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>JAN 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. S. K.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 13

916

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 99 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Radford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Radford d. STREET ADDRESS Route 1, Box 135 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Elaine Reed				4. DATE OF DEATH Month Day Year January 6, 1959			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 14, 1940	
9. AGE (In years last birthday) 18 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William I. Reed		14. MOTHER'S MAIDEN NAME Lucille Lewis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 225-54-6845		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Gastrointestinal Hemorrhage 705.4 DUE TO Thrombocytopenic Purpura Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Nephrotic Syndrome DUE TO (c) Systemic Lupus Erythematosus						INTERVAL BETWEEN ONSET AND DEATH 9 Hours 12 Days 1 Year 1 Year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from September 29, 1958 to January 6, 1959 , that I last saw the deceased alive on January 6, 1959 , and that death occurred at 8:38 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leon G. Smith				DATE SIGNED 1-7-59			
PHYSICIAN'S NAME (Type) Leon G. Smith, M. D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 1/8/59		22c. NAME OF CEMETERY OR CREMATORY Family Cemetery.		22d. LOCATION (City, town, or county) (State) Radford, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR JAN 9 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

018

Page 1 of 1

1. Name of Deceased		2. Sex		3. Race		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician	
11. Signature of Registrar		12. Signature of Medical Examiner		13. Signature of Coroner		14. Signature of Funeral Home		15. Signature of Burial Place	
16. Signature of Cemetery		17. Signature of Undertaker		18. Signature of Burial Place		19. Signature of Burial Place		20. Signature of Burial Place	
21. Signature of Burial Place		22. Signature of Burial Place		23. Signature of Burial Place		24. Signature of Burial Place		25. Signature of Burial Place	
26. Signature of Burial Place		27. Signature of Burial Place		28. Signature of Burial Place		29. Signature of Burial Place		30. Signature of Burial Place	
31. Signature of Burial Place		32. Signature of Burial Place		33. Signature of Burial Place		34. Signature of Burial Place		35. Signature of Burial Place	
36. Signature of Burial Place		37. Signature of Burial Place		38. Signature of Burial Place		39. Signature of Burial Place		40. Signature of Burial Place	
41. Signature of Burial Place		42. Signature of Burial Place		43. Signature of Burial Place		44. Signature of Burial Place		45. Signature of Burial Place	
46. Signature of Burial Place		47. Signature of Burial Place		48. Signature of Burial Place		49. Signature of Burial Place		50. Signature of Burial Place	
51. Signature of Burial Place		52. Signature of Burial Place		53. Signature of Burial Place		54. Signature of Burial Place		55. Signature of Burial Place	
56. Signature of Burial Place		57. Signature of Burial Place		58. Signature of Burial Place		59. Signature of Burial Place		60. Signature of Burial Place	
61. Signature of Burial Place		62. Signature of Burial Place		63. Signature of Burial Place		64. Signature of Burial Place		65. Signature of Burial Place	
66. Signature of Burial Place		67. Signature of Burial Place		68. Signature of Burial Place		69. Signature of Burial Place		70. Signature of Burial Place	
71. Signature of Burial Place		72. Signature of Burial Place		73. Signature of Burial Place		74. Signature of Burial Place		75. Signature of Burial Place	
76. Signature of Burial Place		77. Signature of Burial Place		78. Signature of Burial Place		79. Signature of Burial Place		80. Signature of Burial Place	
81. Signature of Burial Place		82. Signature of Burial Place		83. Signature of Burial Place		84. Signature of Burial Place		85. Signature of Burial Place	
86. Signature of Burial Place		87. Signature of Burial Place		88. Signature of Burial Place		89. Signature of Burial Place		90. Signature of Burial Place	
91. Signature of Burial Place		92. Signature of Burial Place		93. Signature of Burial Place		94. Signature of Burial Place		95. Signature of Burial Place	
96. Signature of Burial Place		97. Signature of Burial Place		98. Signature of Burial Place		99. Signature of Burial Place		100. Signature of Burial Place	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00913

917

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C.	
c. LENGTH OF STAY IN 1b 47x-3		d. STREET ADDRESS 3249 "P" Street, N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) STELLA L. Roebeling		4. DATE OF DEATH Month January Day 24 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1875
9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR Months 4 Days 20	11. IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Jasper H. Lawman		14. MOTHER'S MAIDEN NAME Leanore Ward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Janice R. Marlow-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease (c) Generalized Arteriosclerosis, Severe.		INTERVAL BETWEEN ONSET AND DEATH 1 yr. 2 or 3 years. 5 years plus.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 28, 1958 , to Jan. 24, 1959 , that I last saw the deceased alive on Jan. 24, 1959 , and that death occurred at 1059 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas A. N. Hindman		ADDRESS (Street, city or town, state) 3935 Baltimore St.	
PHYSICIAN'S NAME (Type) Thomas A. N. Hindman		DATE SIGNED 1/24/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 1/26/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR JAN 28 1959	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

796

CERTIFICATE OF DEATH

00914

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE				c. LENGTH OF STAY IN 1b 3 1/2 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4600 GREAT OAK ROAD				e. STREET ADDRESS 4600 GREAT OAK ROAD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First MINNIE Middle LOUISE Last ROESCH		4. DATE OF DEATH		Month JAN. Day 14 Year 19 59	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/18/73	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) IOWA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN M. ROLF				14. MOTHER'S MAIDEN NAME WAITSTILL COOK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 321-18-6852D		17. INFORMANT Address Mrs. Joe A. Hinton, 4600 Great Oak Rd. Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Severe pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c)							1 hr 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 54 , to Jan , 19 59 , that I last saw the deceased alive on Jan 14 , 19 59 , and that death occurred at 12:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE A. D. Bonifant M.D. Sandy Spring, Md. 1/14/59 PHYSICIAN'S NAME (Type) A. D. BONIFANT							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 1/15/59		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. CO., MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR JAN 19 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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DEPARTMENT OF HEALTH
BUREAU OF VITALS
BOSTON

MASSACHUSETTS

918

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (Rural)		c. LENGTH OF STAY IN 1b 16 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ERNEST First WALDO Middle ROGERS Last		4. DATE OF DEATH Month 1 Day 20 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 NOVEMBER 1902
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. NAVY		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MASS.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRIS H. ROGERS		14. MOTHER'S MAIDEN NAME JESSIE HAMILTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW 11		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT DOROTHY H. ROGERS, 40 CORNHILL ST., ANNAPOLIS, MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHOGENIC CARCINOMA RT LUNG DUE TO (c) 1 YEAR INTERVAL BETWEEN ONSET AND DEATH 1 YEAR			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 13, 1959 , to January 20, 1959 , that I last saw the deceased alive on January 19, 1959 , and that death occurred at 3:03A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC DATE SIGNED 1-20-59 ACTUAL SIGNATURE F. S. Caldwell M.D. PHYSICIAN'S NAME (Type) F. S. CALDWELL, LT, MC, USN Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 1-21-59		22b. DATE THEREOF 1-21-59	
22c. NAME OF CEMETERY OR CREMATORY Local Cemetery		22d. LOCATION (City, town, or county) (State) Webster Mass.	
23. FUNERAL DIRECTOR'S SIGNATURE J.M. Taylor Funeral Home, Annapolis, Md.		24a. REC'D BY REGISTRAR DATE JAN 22 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kinner			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

218

919
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>Montgomery.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	c. LENGTH OF STAY IN 1b <i>24 yrs.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8008 Piney Branch Road</i>		d. STREET ADDRESS <i>18008 Piney Branch</i>	
3. NAME OF DECEASED (Type or print) <i>Ralph Edward Ruby</i>		4. DATE OF DEATH Month <i>Jan</i> Day <i>15</i> Year <i>59</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/27/91</i>
9. AGE (In years last birthday) <i>67</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dw. Manager</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Pharmaceuticals</i>	
11. BIRTHPLACE (State or foreign country) <i>Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>RALPH EDWARD RUBY</i>		14. MOTHER'S MAIDEN NAME <i>EMMA BROWN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>214-03-8968</i>	
17. INFORMANT <i>Mrs K Ruby</i>		Address <i>8008 Piney Branch Silver Spring Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Pneumonia Viral</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Acute Coronary Occlusion</i> DUE TO <i>Ch. Weg. Infectionis Mild Decamp.</i> (c) <i>Ch. Weg. Infectionis Mild Decamp.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>immediate</i> <i>24 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Very short breath due to A. Died in Coughing Spell</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <i>19</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1/19/59</i> , 19 <i>59</i> , to <i>1/15/59</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>1/14/59</i> , 19 <i>59</i> , and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Howard T. Morse</i>		ADDRESS (Street, city or town, state) <i>7030 Carroll Ave M.D.</i>	
PHYSICIAN'S NAME (Type) <i>Howard T. Morse</i>		DATE SIGNED <i>1/15/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>1/19/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NATIONAL CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>ARLINGTON, VIRGINIA</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>WARNER E. PUMPHREY, INC.</i> <i>Raymond A. Ziska</i>		ADDRESS <i>SILVER SPRING, MD.</i>	24a. REC'D BY REGISTRAR DATE <i>JAN 19 1959</i>
		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Harris</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF REGISTRAR		10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF CLERK	
JAMES H. HARRIS		Male		45		1918		10:30 AM		Home		Heart Disease		Natural		J. H. Harris		D. M. Harris		A. M. Harris	
12. PLACE OF BIRTH		13. OCCUPATION		14. MARITAL STATUS		15. COLOR		16. EDUCATION		17. RELIGION		18. PREVIOUS ILLNESS		19. PREVIOUS SURGERY		20. PREVIOUS TRAUMA		21. PREVIOUS DRUGS		22. PREVIOUS ALCOHOL	
Baltimore		Teacher		Married		White		High School		Roman Catholic		None		None		None		None		None	
23. SIGNATURE OF REGISTRAR		24. SIGNATURE OF PHYSICIAN		25. SIGNATURE OF CLERK		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS	
J. H. Harris		D. M. Harris		A. M. Harris		B. M. Harris		C. M. Harris		D. M. Harris		E. M. Harris		F. M. Harris		G. M. Harris		H. M. Harris		I. M. Harris	

RECEIVED
JAN 10 1918
BALTIMORE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00917

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

920

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Zion</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montg. CO. Gen.</u>				d. STREET ADDRESS <u>Derwood RFD</u>			
3. NAME OF DECEASED (Type or print) <u>George Danial Russell</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/8/1899</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Perry T. Russell</u>				14. MOTHER'S MAIDEN NAME <u>Margaret M. Campbell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary Russell (wife)</u>		Address <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2</u> hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/19/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/22/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion.,</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Zion, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 21 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

921

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 47 MIN. d. NAME OF HOSPITAL (If not in hospital, give street address) MONTGOMERY COUNTY GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highland 13 X - 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SARAH Middle - Last SCAGGS		4. DATE OF DEATH Month JANUARY Day 6 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Unknown	8. DATE OF BIRTH 2-22-1875
9. AGE (In years last birthday) 83		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Wesley Moore		14. MOTHER'S MAIDEN NAME Mary Cissel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Phillip Moore, Silver Spring, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition + Secondary anemia		INTERVAL BETWEEN ONSET AND DEATH 6 mos. 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 5, 1959 , to January 6, 1959 , that I last saw the deceased alive on January 5, 1959 , and that death occurred at 11:47 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Charles S. Whitaker M.D.			
PHYSICIAN'S NAME (Type) C.S. WHITAKER, M. D.		CLARKSVILLE, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-8-59	22c. NAME OF CEMETERY OR CREMATORY St. Marks	22d. LOCATION (City, town, or county) (State) Highland, Md
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE JAN 8 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kinn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS

DEPARTMENT OF HEALTH

IN THE COUNTY OF

CITY OF

WARD OF

STREET

APARTMENT

ROOM

FLAT

HOUSE

BOAT

TRAILER

OTHER

PLACE

DATE

TIME

BY

AT

AGE

SEX

RACE

RELIGION

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OCCUPATION

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last META COCHRANE SCANTLIN		4. DATE OF DEATH Month Day Year Jan. 17, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 1, 1885
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 10 16	11. IF UNDER 24 HRS. Hours Min. 10 16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Alabama
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles Rufus Cochrane		14. MOTHER'S MAIDEN NAME Jennie Sanford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Daug. Mrs. Roland Rice		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis with Hemiplegia DUE TO 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO 24 years (c) Generalized arteriosclerosis 57 years		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 29, 1958 to Jan 17, 1959 , that I last saw the deceased alive on Jan 17, 1959 , and that death occurred at 8:00 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen R. Hulburt		ADDRESS (Street, city or town, state) DATE SIGNED 3000 Dent Place N.W. Wash. D.C. 1-18-59	
PHYSICIAN'S NAME (Type) STEPHEN R. HULBURT		3000 Dent Pl., N. W., Washington, DC	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-20-59	22c. NAME OF CEMETERY OR CREMATORY Baldwin Meth.Ch.Cem.	22d. LOCATION (City, town, or county) (State) Millersville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JAN 20 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

923

CERTIFICATE OF DEATH

00920

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland - b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 9 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chevy Chase		d. STREET ADDRESS 3219 Coquelin Terrace	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hillcrest San.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FLAXIE Middle EVA Last SCATES		4. DATE OF DEATH Month Jan. Day 29 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17, 1883
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR 12 Months Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Andrew Connelly		14. MOTHER'S MAIDEN NAME Charlotte Sanders	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT Lyndon Scates, 3210 Coquelin Terrace Chevy Chase, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, general 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT. 1957 to Jan. 29, 1959 , that I last saw the deceased alive on Jan. 29, 1959 , and that death occurred at 6 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 1-29-59	
ACTUAL SIGNATURE Leo M. Curtis M.D.			
PHYSICIAN'S NAME (Type) LEO M. CURTIS		8218 Wisconsin Ave., Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 31, 1959	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR JAN 30 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

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VS A15 (4)
15M 9/55

924 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conshohocken ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 417 Spring Mill Ave.			
3. NAME OF DECEASED (Type or print) First Thelma Middle Mae Last SCHMEIG				4. DATE OF DEATH Month January Day 15 Year 19 59			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-27-13	
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Lewis E. Boswell				14. MOTHER'S MAIDEN NAME Mary M. Lightkep			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 181-10-7331		17. INFORMANT (H) Edw. J. Schmeig, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 26 months							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from January 2, 19 59 , to January 15, 19 59 , that I last saw the deceased alive on January 15, 19 59 , and that death occurred at 8:46A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John Wood Davis				ADDRESS (Street, city or town, state) U. S. Naval Hospital		DATE SIGNED 1-15-59	
PHYSICIAN'S NAME (Type) J. W. DAVIS, LT, MC, USN				Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 1-16-59		22b. DATE THEREOF 1-16-59		22c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery		22d. LOCATION (City, town, or county) (State) Norristown Pa	
23. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home, 4748 Wisc. Ave., NW, Wash, D.C.				24a. REC'D BY REGISTRAR JAN 19 59		24b. REGISTRAR'S SIGNATURE Arthur L. Fink	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

As a result of the above, the following is proposed:

925

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Massachusetts b. COUNTY 58x-3	
c. LENGTH OF STAY IN 1b 70 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hudson		d. STREET ADDRESS Hunter Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Albert Richardson SCHOFIELD		4. DATE OF DEATH Month Day Year January 23 1959			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-22-94	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Anderson Schofield		14. MOTHER'S MAIDEN NAME Clare BRADDOCK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Helen Manning, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO Pemphigoid skin reaction with secondary (c) staphylococcal infection					INTERVAL BETWEEN ONSET AND DEATH 6 hrs. Unknown 6 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple sclerosis - 25 years					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from November 14, 1958 , to January 23, 1959 , that I last saw the deceased alive on January 23, 1959 , and that death occurred at 12:05 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE J. T. Horgan		M.D. U. S. Naval Hospital, NMMC		DATE SIGNED 1-23-58	
PHYSICIAN'S NAME (Type) J. T. HORGAN, LCDR, MC, USN		Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-27-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) Arlington		(State) Va.			
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey		ADDRESS Funeral Home, Bethesda, Md.		24a. REC'D BY REGISTRAR AN 27 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION			

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00923

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>1 Hr. 55 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hosp.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Helen Gladys Sengstack</u>		4. DATE OF DEATH Month <u>1</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-88</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George G. Rowe</u>		14. MOTHER'S MAIDEN NAME <u>Kate Titus</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John Sengstack</u>		Address <u>7920 4th pl. Baltimore, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1/20/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Company</u>		24. REC'D BY REGISTRAR <u>JAN 20 '59</u>	
24a. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

783
CERTIFICATE OF DEATH

00924

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>3 1/2 hrs</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Randolph Barksdale Shackelford</i>				4. DATE OF DEATH <i>Jan. 25 1959</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6-6-90</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Real Estate Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Boss & Phelps</i>		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>	
13. FATHER'S NAME <i>William W. Shackelford</i>				14. MOTHER'S MAIDEN NAME <i>Susan Barksdale</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>yes</i>		17. INFORMANT Address <i>medical records</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ruptured peptic ulcer (gastric)</i> 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bronchogenic carcinoma, right lung.</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I attended the deceased from _____, 19____, to <i>25 Jan</i> , 1959, that I last saw the deceased alive on <i>25 Jan</i> , 1959, and that death occurred at <i>7:30 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Seruch T. Kimble</i>				ADDRESS (Street, city or town, state) <i>929 Picking Drive Silver Spring, Md</i>			
PHYSICIAN'S NAME (Type) <i>SERUCH T. KIMBLE</i>				DATE SIGNED <i>25 Jan 59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>1/28/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>PARKLAWN CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>MONTGOMERY COUNTY, MARYLAND</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>WARNER E. PUMPHREY, INC. SILVER SPRING, MD.</i>				24a. REC'D BY REGISTRAR <i>DATE JAN 28 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kraus</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		AGE	
OCCUPATION		SEX	
EDUCATION		RACE	
MARRIAGE		RELIGION	
BIRTH		DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		TIME	
PLACE		CITY	
COUNTY		STATE	



926

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. LENGTH OF STAY IN 1b <u>10 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Asbury Methodist Home</u>				d. STREET ADDRESS <u>Gaithersburg</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>E</u> Last <u>SHAFFER</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 17 1871</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u> Hours <u>59</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPING NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Wm. L. Shaffer</u>				14. MOTHER'S MAIDEN NAME <u>Lydia C. Hoffman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Asbury Methodist Home Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBROVASCULAR ACCIDENT</u> DUE TO (c) <u>ARTEROSCLEROSIS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1-2-59</u> <u>1-2-59</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. m.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>NOV</u> , 19 <u>55</u> to <u>JAN 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JAN. 2</u> , 19 <u>59</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sarah E. Glover</u>				M.D. <u>10128 CEDAR LANE KENSINGTON, MD</u>			
PHYSICIAN'S NAME (Type) <u>Sarah E. Glover, M.D.</u>				<u>10128 CEDAR LANE Kensington, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-6-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hampstead Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Christ E. Garton</u>				ADDRESS <u>Gaithersburg Md</u>		24a. REC'D BY REGISTRAR <u>JAN 6 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Ann D. Thomas</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED Wm. L. Shaffer		AGE 12 YRS		SEX Male		RACE White	
DATE OF DEATH Jan 3 1923		PLACE OF DEATH Home		CITY St. Louis		COUNTY St. Louis	
OCCUPATION Student		EDUCATION High School		MARRIAGE Never		PREVIOUS ILLNESS None	
CAUSE OF DEATH Pneumonia		PERIOD OF ILLNESS 10 days		TREATMENT Physician's care		PLACE OF BURIAL St. Louis	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		SIGNATURE OF DECEASED Wm. L. Shaffer		SIGNATURE OF NEXT OF KIN J. H. Smith	
DATE OF SIGNATURE Jan 3 1923		DATE OF SIGNATURE Jan 3 1923		DATE OF SIGNATURE Jan 3 1923		DATE OF SIGNATURE Jan 3 1923	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

927

CERTIFICATE OF DEATH

06926

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Mentgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4111 Ingomar St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>J.</u> Last <u>Sheehy</u>		4. DATE OF DEATH Month <u>1</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-80-78</u>
9. AGE (In years last birthday) <u>78 yrs.</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Maurice W. Quinlan</u>		14. MOTHER'S MAIDEN NAME <u>Johanna O'Connor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>John J. Sheehy</u>		Address <u>Sen Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right hemiplegia, severe</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral thrombosis</u> DUE TO (c) <u>Arteriosclerosis, general</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>6 days</u> <u>5 wks +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lupus erythematosus, subacute</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt. fell in front yard and fractured rt. clavicle</u>	
20c. TIME OF INJURY Hour (a.m.) <u>12</u> Month <u>28</u> Day <u>1959</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>4109 Ingomar St. N.W.</u> (County) <u>D.C.</u> (State) <u>DC</u>	
21. I certify that I attended the deceased from <u>1957</u> to <u>Jan 2</u> , 1959, that I last saw the deceased alive on <u>Jan 2</u> , 1959, and that death occurred at <u>7:20 P.M.</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>3921 Ingomar St. N.W.</u>		DATE SIGNED <u>1-2-59</u>	
ACTUAL SIGNATURE <u>Stewart Clapp</u>		M.D. <u>Wash 15, D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JAN 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

928

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 3 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 2024 Add Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rhoda Bertha Shenk		4. DATE OF DEATH Month Day Year January 2, 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 1924
9. AGE (In years last birthday) 34 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) IBM Operator		10b. KIND OF BUSINESS OR INDUSTRY Unascertainable	11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Edwin V. Olsen	
14. MOTHER'S MAIDEN NAME Rhoda Brackett		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. Unavailable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTROINTESTINAL HEMORRHAGE 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ACUTE LEUKEMIA DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HEMORRHAGE FROM RENAL PELVES			INTERVAL BETWEEN ONSET AND DEATH HOURS MONTHS
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 30, 19 58 , to January 2, 19 59 , that I last saw the deceased alive on January 2, 19 59 , and that death occurred at 12:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 1-2-59 The National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE Harold R. Silberman M.D.		PHYSICIAN'S NAME (Type) Harold R. Silberman, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JAN 6, 1959	22c. NAME OF CEMETERY OR CREMATORY PARK LAWN Cem.	22d. LOCATION (City, town, or county) (State) BROOKLYN New York
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Sons		ADDRESS 1756 PA AVE. N.W. WASH D.C.	24a. REC'D BY REGISTRAR DATE JAN 5 '59
24b. REGISTRAR'S SIGNATURE William S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

See last page

Full Name

Age

Sex

Color

Place of Birth

Time of Death

Place of Death

Street and Number

City and State

County

Date of Birth

Place of Birth

Time of Death

Place of Death

Street and Number

City and State

County

Date of Birth

Place of Birth

Time of Death

Place of Birth

Time of Death

Place of Death

The undersigned, a duly qualified physician, do hereby certify that the above is a true and correct statement of the facts as to the death of the person named above, and that the same was caused by the disease or injury stated above.



Signature

Date of Death

Time

Place

The undersigned, a duly qualified physician, do hereby certify that the above is a true and correct statement of the facts as to the death of the person named above, and that the same was caused by the disease or injury stated above.

The undersigned, a duly qualified physician, do hereby certify that the above is a true and correct statement of the facts as to the death of the person named above, and that the same was caused by the disease or injury stated above.

The undersigned, a duly qualified physician, do hereby certify that the above is a true and correct statement of the facts as to the death of the person named above, and that the same was caused by the disease or injury stated above.

The undersigned, a duly qualified physician, do hereby certify that the above is a true and correct statement of the facts as to the death of the person named above, and that the same was caused by the disease or injury stated above.

The undersigned, a duly qualified physician, do hereby certify that the above is a true and correct statement of the facts as to the death of the person named above, and that the same was caused by the disease or injury stated above.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md. b. COUNTY MONT.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Saint Hosp.		d. STREET ADDRESS 9301 Weaver Pl. Silver Spring	
3. NAME OF DECEASED (Type or print) WALTER Farrow First Middle Last		4. DATE OF DEATH Jan. 20 1959 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/27/67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govt employee		10b. KIND OF BUSINESS OR INDUSTRY Govt worker	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? American	
13. FATHER'S NAME Walter Siddall		14. MOTHER'S MAIDEN NAME Em Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		17. INFORMANT Patients & RPT Address Wash. San. Htg. T.P.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 cardiac arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) progressive arteriosclerosis DUE TO (c) old age		INTERVAL BETWEEN ONSET AND DEATH minutes 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic insufficiency of kidneys, diverticulitis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 19 1951 , to present date 1959 , that I last saw the deceased alive on Jan 19 1959 , and that death occurred at 2:40 p.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Philip W. Harrison		DATE SIGNED 5911 16th St N.W. Wash. D.C. 1/20/59	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-23-59	22c. NAME OF CEMETERY OR CREMATORY Congressional	22d. LOCATION (City, town, or county) (State) Wash. D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		24a. REC'D BY REGISTRAR H & Mass Ave NE	
ADDRESS Wash. D.C.		DATE JAN 22 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00929

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Point of Rocks 108-2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co. Gen. Hosp.			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Richard Middle Sims Last			4. DATE OF DEATH Month Jan. Day 23 , Year 1959		
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/28/1920		9. AGE (In years last birthday) 38 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John Sims			14. MOTHER'S MAIDEN NAME Gertrude Neuman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) US ARMY		16. SOCIAL SECURITY NO.		17. INFORMANT Address Police Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 823 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Severance of left carotid A. & Lt. Jugular V. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of 2nd cervical vertebra					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger involved in auto accident - car went out of control - into embankment			
20c. TIME OF INJURY Month, Day, Year 4:30 p.m. 1/23/59 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway	20f. (City or town) nr Derwood	(County) Montg.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/23/59	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REINTERMENT Burial	22b. DATE THEREOF 1/27/59	22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Baptist.		22d. LOCATION (City, town, or county) (State) Lucketts, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE 29 '59	24b. REGISTRAR'S SIGNATURE Arthur E. H...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of Death: Jan 15, 1925

5. Place of Death: Home

6. Cause of Death: Heart Disease

7. Manner of Death: Natural

8. Signature of Medical Examiner: [Signature]

9. Signature of Coroner: [Signature]

10. Signature of Registrar: [Signature]

11. Date of Filing: Jan 16, 1925

12. File Number: 12345

13. Remarks: None

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00930

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

930

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 15 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Colesville - Fairland Rd.				/d. STREET ADDRESS Colesville - Fairland Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carrie B Smith				4. DATE OF DEATH Month Jan. Day 10 Year 1959			
5. SEX female	6. COLOR OR RACE col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1 1907		9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Va.		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Stanley Smith Address Colesville --Fairland Rd. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Jan. 14, 1959			
22a. BURIAL, CREMATION, REBURY (Specify) Burial		22b. DATE THEREOF 1/14/59		22c. NAME OF CEMETERY OR CREMATORY Ash Memorial.,		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sumner				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE JAN 16 '59	
				24b. REGISTRAR'S SIGNATURE C. H. H. H.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

931

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Green Rest Home, 14326 Colesville Rd. Silver Spring, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LULIE WELLS SMITH				4. DATE OF DEATH Month Jan. Day 13, Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1865	9. AGE (In years last birthday) 93 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Dr. Charles A. Wells				14. MOTHER'S MAIDEN NAME Mary Lucretia Hyatt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Rex C. Smith, 4520 S. Chelsea Lane, Bethesda, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiac vascular disease DUE TO 10 yrs (c) Generalized arteriosclerosis DUE TO 15 yrs							INTERVAL BETWEEN ONSET AND DEATH 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov , 19 58 , to Jan 13 , 19 59 , that I last saw the deceased alive on Jan 9 , 19 59 , and that death occurred at 10:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Family Spring DATE SIGNED 1/14/59							
ACTUAL SIGNATURE A. D. Bonifant M.D.				PHYSICIAN'S NAME (Type) A. D. BONIFANT			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 16, 1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg Rd., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Cherry Chase Funeral Home				24a. REC'D BY REGISTRAR DATE JAN 16 '59		24b. REGISTRAR'S SIGNATURE Clarence S. Knaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

932

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington, D.C. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X (15)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Nursing Home		d. STREET ADDRESS 5425 Connecticut Ave., N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NATHAN Middle SONDHEIMER Last SONDHEIMER		4. DATE OF DEATH Month January Day 25 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1879
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant - Retired		10b. KIND OF BUSINESS OR INDUSTRY Clothing Store	11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME David Sondheim		14. MOTHER'S MAIDEN NAME Lena Trimpe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Dr. Daniel Sondheim - 5300 Elliott Rd., Westmoreland Hills, Beth.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 hr 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Constrictive Heart Failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 8, 1939 , to 1-25 , 1959, that I last saw the deceased alive on 1-25 , 1959, and that death occurred at 7:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Irvin Bunka, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 3701 Conn. Ave. N.W. WASH. D.C. 1-25-59	
PHYSICIAN'S NAME (Type) Irvin Bunka, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 28, 1959	
22c. NAME OF CEMETERY OR CREMATORY Washington Hebrew Cong. Cem.		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & sons - 3501 14th St., N.W.		24a. REC'D BY REGISTRAR DATE JAN 29 '59	
		24b. REGISTRAR'S SIGNATURE Arthur E. H.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

033

<p>1. Name of deceased: JOHN W. BROWN</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: 1890-01-15</p>		<p>4. Place of birth: Baltimore, Md.</p>	
<p>5. Date of death: 1945-03-10</p>		<p>6. Place of death: Baltimore, Md.</p>	
<p>7. Cause of death: Heart Disease</p>		<p>8. Duration of illness: 10 days</p>	
<p>9. Name of physician: Dr. J. W. Smith</p>		<p>10. Name of funeral home: None</p>	
<p>11. Name of informant: John W. Brown</p>		<p>12. Address of informant: 1234 Main St., Baltimore, Md.</p>	
<p>13. Signature of informant: <i>[Signature]</i></p>		<p>14. Signature of physician: <i>[Signature]</i></p>	
<p>15. Date of completion: 1945-03-15</p>		<p>16. Name of registrar: John W. Brown</p>	

333
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. Gen. Hospital				e. STREET ADDRESS 25508 Woodfield Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Sprague Last Sprague				4. DATE OF DEATH Month January Day 9 Year 19 59			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/18/16		9. AGE (In years lost birthday) 42 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) newspaper distributor		10b. KIND OF BUSINESS OR INDUSTRY Evening Star		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Sprague				14. MOTHER'S MAIDEN NAME Isabella Younger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-12-5987		17. INFORMANT Hospital Records		Address Olney, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver, nephritis 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic alcoholism DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 years 25 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myelitis, undetermined type							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 9/27/55 , 19____, to 1/9/59 , 19____, that I last saw the deceased alive on 1/9/59 , 19____, and that death occurred at 1:47 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Main Street DATE SIGNED 1/10/59							
ACTUAL SIGNATURE Dr. G. F. Meadors				M.D. Damascus, Maryland			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 12, 1959		22c. NAME OF CEMETERY OR CREMATORY Elmwood		22d. LOCATION (City, town, or county) (State) Shepherdstown, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Mohaworth				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE JAN 13 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Sex	
Age at Death		Date of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Physician		Signature of Registrar		Signature of Informant	
Date of Report		Time of Report		Place of Report	
Name of Informant		Relationship to Deceased		Signature of Informant	
Date of Informant's Statement		Time of Informant's Statement		Place of Informant's Statement	
Name of Informant's Physician		Signature of Informant's Physician		Date of Informant's Physician's Statement	
Name of Informant's Hospital		Signature of Informant's Hospital		Date of Informant's Hospital's Statement	
Name of Informant's City		Signature of Informant's City		Date of Informant's City's Statement	
Name of Informant's State		Signature of Informant's State		Date of Informant's State's Statement	
Name of Informant's Country		Signature of Informant's Country		Date of Informant's Country's Statement	
Name of Informant's Continent		Signature of Informant's Continent		Date of Informant's Continent's Statement	
Name of Informant's Hemisphere		Signature of Informant's Hemisphere		Date of Informant's Hemisphere's Statement	
Name of Informant's Planet		Signature of Informant's Planet		Date of Informant's Planet's Statement	
Name of Informant's Galaxy		Signature of Informant's Galaxy		Date of Informant's Galaxy's Statement	
Name of Informant's Universe		Signature of Informant's Universe		Date of Informant's Universe's Statement	

MASSACHUSETTS DEPARTMENT OF HEALTH
BIRTH AND DEATH RECORDS
JAN 12 1970
BOSTON, MA

785
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>17 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
4. DATE OF DEATH Month <u>1</u> Day <u>14</u> Year <u>19 59</u>							
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/4/93</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u> Hours <u>19</u> Min. <u>59</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles P. Swanson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Musch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Pl's hosp. Record</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compensatory Cardiac Failure</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma of lungs</u> DUE TO (c) <u>about one yr.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12/28/1958</u> , to <u>1/14/1959</u> , that I last saw the deceased alive on <u>1/14/1959</u> , and that death occurred at <u>9:55 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Takoma Park Md.</u> DATE SIGNED <u>1/15/59</u>							
ACTUAL SIGNATURE <u>Robert A Hare</u> M.D.				PHYSICIAN'S NAME (Type) <u>Robert A Hare, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>COLLEGE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Lund Home</u> ADDRESS <u>2112 Dundalk</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		MILITARY SERVICE		MARITAL STATUS		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH									
JAMES H. HARRIS		M		45		1880		NEW YORK		NEW YORK		NEW YORK		WHITE		METHODIST		MARRIED		HIGH SCHOOL		LABORER		ARMY		SINGLE		JAN 15 1918		NEW YORK		NEW YORK		NEW YORK									
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S CITY OF BIRTH		MOTHER'S CITY OF BIRTH		FATHER'S COUNTRY OF BIRTH		MOTHER'S COUNTRY OF BIRTH		FATHER'S RELIGION		MOTHER'S RELIGION		FATHER'S MARRIAGE		MOTHER'S MARRIAGE		FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S CITY OF DEATH		MOTHER'S CITY OF DEATH		FATHER'S COUNTRY OF DEATH		MOTHER'S COUNTRY OF DEATH	
JOHN H. HARRIS		MARY H. HARRIS		LABORER		HOUSEWIFE		NEW YORK		NEW YORK		NEW YORK		NEW YORK		WHITE		METHODIST		METHODIST		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER		LABORER			
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH					
JAN 15 1918		NEW YORK		NEW YORK		NEW YORK		JAN 15 1918		NEW YORK		NEW YORK		NEW YORK		JAN 15 1918		NEW YORK		NEW YORK		NEW YORK		JAN 15 1918		NEW YORK		NEW YORK		NEW YORK		JAN 15 1918		NEW YORK		NEW YORK		NEW YORK					

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home for files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

Items 18&19 Film 236 1-50-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00935

934

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u>		c. LENGTH OF STAY IN 1b <u>X</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5309 Bangor Dr.</u>			d. STREET ADDRESS <u>5309 Bangor Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>G G</u> Last <u>Stagg</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>15</u> Year <u>1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/5/1906</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public Relations</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Connecticut</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>					
13. FATHER'S NAME <u>Robert Stagg</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Berry</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>040-93-3817</u>		17. INFORMANT <u>June W. Stagg-wife-same as 2d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>322.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Aspiration of Gastric Contents</u> (c) <u>.14% ethel alcohol and 2.32 mg% barbituate</u> cause lost.					INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> o. m. <u>—</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>—</u>	(County) <u>—</u>	(State) <u>—</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broshart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Jan. 16, 1959</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broshart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>	22b. DATE THEREOF <u>1/19/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Haven</u>		22d. LOCATION (City, town, or county) (State) <u>New Haven, Connecticut</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JAN 20 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles L. Kline</u>

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

028

STATE OF NEW YORK
DEPARTMENT OF HEALTH

1. Name of Deceased: John J. Smith

2. Sex: Male

3. Age: 45

4. Date of Birth: Jan. 15, 1900

5. Place of Birth: New York City

6. Usual Residence: 123 Main St., New York City

7. Date of Death: Jan. 20, 1945

8. Time of Death: 10:30 AM

9. Place of Death: Home

10. Cause of Death: Myocardial Infarction

11. Manner of Death: Natural

12. Signature of Medical Examiner: [Signature]

13. Date of Signature: Jan. 21, 1945

14. Signature of Coroner: [Signature]

15. Date of Signature: Jan. 21, 1945

16. Signature of Registrar: [Signature]

17. Date of Signature: Jan. 21, 1945

935

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>22 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				e. STREET ADDRESS <u>2604-McCOMBS AVE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY Elizabeth Sterling</u>				4. DATE OF DEATH Month Day Year <u>JAN. 1 1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 23-1910</u>	9. AGE (In years lost birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Norfolk, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>Charles Herring</u>			
14. MOTHER'S MAIDEN NAME <u>OLA EARLY</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT Address <u>George FRANKLIN Sterling - Husband</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis, severe, postoperative</u> 570.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infection of ileum</u> DUE TO (c) <u>Volvulus of ileum</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Approx 10 days</u> <u>23 da</u> <u>23 da</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adhesions secondary to surgical procedure</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>12/10</u> , 19 <u>58</u> , to <u>1/1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 1</u> , 19 <u>59</u> , and that death occurred at <u>2:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John O. Robben M.D.</u>				ADDRESS (Street, city or town, state) <u>7930 GEORGIA AVE SILVER SPRING MD</u>			
PHYSICIAN'S NAME (Type) <u>JOHN O. ROBBEN MD</u>				DATE SIGNED <u>1-5-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 5 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED (Print or write full name)		SEX (Male or Female)		RACE (Print or write race)	
DATE OF BIRTH (Print or write date)		PLACE OF BIRTH (Print or write place)		PLACE OF DEATH (Print or write place)	
TIME OF DEATH (Print or write time)		CAUSE OF DEATH (Print or write cause)		MANNER OF DEATH (Print or write manner)	
SIGNATURE OF DECEASED (Print or write signature)		SIGNATURE OF WITNESS (Print or write signature)		SIGNATURE OF PHYSICIAN (Print or write signature)	
DATE OF SIGNATURE (Print or write date)		PLACE OF SIGNATURE (Print or write place)		PLACE OF SIGNATURE (Print or write place)	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00937

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>4 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1100 Spring St.</u>				d. STREET ADDRESS <u>1100 Spring St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Walter Charles Stewart</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/10/02</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept store</u>		11. BIRTHPLACE (State or foreign country) <u>Omaha, Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIS WARDER STEWART</u>				14. MOTHER'S MAIDEN NAME <u>CELIA BESSIE WARNES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WW #2</u>		17. INFORMANT <u>Mrs. Ruth W. Howe</u>		Address <u>5024 25th Ave. Hillcrest Estates, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>JAN 13 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
LABORATORY

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION	
11. PRESENT ADDRESS		12. DATE OF DEATH		13. TIME OF DEATH		14. PLACE OF DEATH		15. CAUSE OF DEATH	
16. MANNER OF DEATH		17. SIGNATURE OF MEDICAL EXAMINER		18. SIGNATURE OF WITNESS		19. SIGNATURE OF CLERK		20. SIGNATURE OF JURY	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF PRIEST		24. SIGNATURE OF MINISTER		25. SIGNATURE OF RABBI	
26. SIGNATURE OF CHAPLAIN		27. SIGNATURE OF FUNERAL HOME		28. SIGNATURE OF BURIAL PLACE		29. SIGNATURE OF CREMATOR		30. SIGNATURE OF OTHER	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
FOR STATE LABORATORY

937

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>5907 Lone Oak Drive</u>			
e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES							
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Hammond</u> Last <u>Stone</u>				4. DATE OF DEATH Month <u>January</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 30, 1882</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>5</u> Hours <u>19</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Massach</u>	
11. BIRTHPLACE (State or foreign country) <u>USA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>James Ephrim Stone</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Hammond</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Hattie G. Stone</u>		Address <u>5907 Lone Oak Drive Bethesda Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> DUE TO <u>541.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Perforation chronic duodenal ulcer</u> (c) <u>2-3 days</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1/29</u> , 19 <u>59</u> , to <u>1/30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/30</u> , 19 <u>59</u> , and that death occurred at <u>9:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clifford S. Norton</u>				ADDRESS (Street, city or town, state) <u>Bethesda Md.</u>			
DATE SIGNED <u>1/30/59</u>							
PHYSICIAN'S NAME (Type) <u>Chapman Funeral Home</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>2/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pardown Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Pike Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chapman Funeral Home</u>				ADDRESS <u>5783 Wisconsin Ave Wash DC.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 4 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



938

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONT</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>4 - days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>5515-MCKINLEY ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Lloyd</u> Middle <u>Edward</u> Last <u>STONNELL</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>1</u> Year <u>19 59</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 3 1886</u>		
9. AGE (In years lost <u>72</u> day) yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>28</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Cumtland county Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Kemper Iven Stonnell</u>				14. MOTHER'S MAIDEN NAME <u>FANNY WADE</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Above</u> <u>Mrs Colinda B. Stonnell, wife</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis, left ant desc. coronary Art. 3 day</u> DUE TO (c) <u>Coronary sclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>55</u> , to <u>12/31</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/31</u> , 19 <u>58</u> , and that death occurred at <u>3:35 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4890 BATTERY LA</u> DATE SIGNED <u>1/1/59</u>								
ACTUAL SIGNATURE <u>Charles Savarese, MD</u>		M.D. <u>4890 BATTERY LA</u>						
PHYSICIAN'S NAME (Type) <u>CHARLES SAVARESE MD</u>		<u>BETHESDA, MD</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>		
23. REGISTRAR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 5 '59</u>		
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FOR STATE HEALTH DEPARTMENT

Any delay in filing this certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be filed with the State Board of Health or the local health officer. The certificate should be filed with the State Board of Health or the local health officer. The certificate should be filed with the State Board of Health or the local health officer.

TO: VS. A15ME
exec 4 shc
TO FILE
BM 2/57

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

939

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>50 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>620 Ritchie Ave</u>			d. STREET ADDRESS <u>620 Ritchie Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>May</u> Last <u>Taylor</u>			4. DATE OF DEATH Month <u>jun</u> Day <u>4</u> Year <u>1959</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-4-77</u>		9. AGE (in years last birthday) <u>81</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Alfred Snowden</u>			14. MOTHER'S MAIDEN NAME <u>Charlotte Boyd</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Vernard W. Taylor</u> Address <u>Stm 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>L.O.I.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-4-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park,</u>	
				22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

GENERAL DIRECTOR, or its designated agent, prior to burial, cremation, or removal of remains.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

038

WILLIAM DOMIN

DATE OF DEATH
1944

TIME OF DEATH
11:00 AM

PLACE OF DEATH
HOME

AGE
70

SEX
MALE

RACE
WHITE

RELIGION
METHODIST

EDUCATION
HIGH SCHOOL

OCCUPATION
RETIRED

DATE OF BIRTH
1874

TIME OF BIRTH
10:00 AM

PLACE OF BIRTH
BALTIMORE

AGE
70

SEX
MALE

RACE
WHITE

RELIGION
METHODIST

EDUCATION
HIGH SCHOOL

OCCUPATION
RETIRED

DATE OF DEATH
1944

TIME OF DEATH
11:00 AM

PLACE OF DEATH
HOME

AGE
70

SEX
MALE

RACE
WHITE

RELIGION
METHODIST

EDUCATION
HIGH SCHOOL

OCCUPATION
RETIRED

DATE OF BIRTH
1874

TIME OF BIRTH
10:00 AM

PLACE OF BIRTH
BALTIMORE

AGE
70

SEX
MALE

RACE
WHITE

RELIGION
METHODIST

EDUCATION
HIGH SCHOOL

OCCUPATION
RETIRED

DATE OF DEATH
1944

TIME OF DEATH
11:00 AM

PLACE OF DEATH
HOME

AGE
70

SEX
MALE

RACE
WHITE

RELIGION
METHODIST

EDUCATION
HIGH SCHOOL

OCCUPATION
RETIRED

DATE OF BIRTH
1874

TIME OF BIRTH
10:00 AM

PLACE OF BIRTH
BALTIMORE

AGE
70

SEX
MALE

RACE
WHITE

RELIGION
METHODIST

EDUCATION
HIGH SCHOOL

OCCUPATION
RETIRED

DATE OF DEATH
1944

TIME OF DEATH
11:00 AM

PLACE OF DEATH
HOME

AGE
70

SEX
MALE

RACE
WHITE

RELIGION
METHODIST

EDUCATION
HIGH SCHOOL

OCCUPATION
RETIRED

DATE OF BIRTH
1874

TIME OF BIRTH
10:00 AM

PLACE OF BIRTH
BALTIMORE

AGE
70

SEX
MALE

RACE
WHITE

RELIGION
METHODIST

EDUCATION
HIGH SCHOOL

OCCUPATION
RETIRED

340

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 X - 3 d. STREET ADDRESS 108 15th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Maxzeller Middle Leonard Last THOMAS			4. DATE OF DEATH Month January Day 22 Year 19 59				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 10-20-96		9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months 2 Days 19 Hours 59 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.		11. BIRTHPLACE (State or foreign country) So. Carolina			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Lee THOMAS					
14. MOTHER'S MAIDEN NAME Annie THOMAS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI					
16. SOCIAL SECURITY NO.		17. INFORMANT (W) Mrs. Selma D. Thoams, same as #2 above					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 hrs					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 16 , 19 59 , to January 22 , 19 59 , that I last saw the deceased alive on January 22 , 19 59 , and that death occurred at 8:19A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital, NNMC 1-22-59							
ACTUAL SIGNATURE R. G. Muth		M.D. U. S. Naval Hospital, NNMC					
PHYSICIAN'S NAME (Type) R. G. MUTH, LT. MC, USN		Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-27-59		22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial			
22d. LOCATION (City, town, or county) (State) Suitland Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Marb. Bros. Sr.		ADDRESS Hall Bros. Funeral Home, 621 Fla. Ave, NW, Wash. DC			
24a. REC'D BY REGISTRAR JAN 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

941

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lauderdale Spencerville - Md. Thompson Road - Spencerville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAWRENCE HOWARD THOMPSON</u>		4. DATE OF DEATH Month Day Year <u>Jan - 5 - 1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 19, 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Thompson</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Ruth O. Thompson, Thompson Road - Spencerville Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma sigmoid</u> <u>153.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Mitastases</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr 9 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/1</u> , 19 <u>58</u> , to <u>1/5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/4</u> , 19 <u>59</u> , and that death occurred at <u>6:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Sandy Spring 1/5/59</u>	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan-7-59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Spencerville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>254 Carroll St.</u>	
24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>JAN 7 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

ONE 18

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

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PLACE OF DEATH

CAUSE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

942
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 59 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				d. STREET ADDRESS 1335 Saratoga Avenue, N.E.			
3. NAME OF DECEASED (Type or print) First Robert Middle Pierce Last Thompson				4. DATE OF DEATH Month January Day 26 , Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 31, 1901	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Illustrator				10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Ovington Thompson				14. MOTHER'S MAIDEN NAME Bertha Pierce			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) 20 yrs. INTERVAL BETWEEN ONSET AND DEATH 36 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital Absence, Left Kidney							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from November 28 , 19 58 , to January 26 , 19 59 , that I last saw the deceased alive on January 26 , 19 59 , and that death occurred at 1:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/27/59 ACTUAL SIGNATURE Louis Gillespie Jr. M.D. The National Institutes of Health Bethesda 14, Maryland PHYSICIAN'S NAME (Type) LOUIS GILLESPIE, JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 1-29-59		22c. NAME OF CEMETERY OR CREMATORY Eden Hill Crematory		22d. LOCATION (City, town, or county) (State) Switzland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co				ADDRESS 1400 Chapin St NW		24a. REC'D BY REGISTRAR JAN 30 '59	
24b. REGISTRAR'S SIGNATURE Carlton S. House							

The Child Center

2002

References

DOI: 10.1002/jbm.b

side

Abstract:

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William O'Neil, Jr.

021017 200150

The Clinical Center

786

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Tower Heights</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>8 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitation & Hosp.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>W. Hyattsville</i> <i>16-15-2</i>	
3. NAME OF DECEASED (Type or print) First <i>Stephen</i> Middle <i>Broadus</i> Last <i>Tilley</i>		d. STREET ADDRESS <i>5010 37th. Ave.</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Cauc.</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-9-68</i>	
9. AGE (In years last birthday) <i>90</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Printer - Gov't.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>D.C.</i>	
11. BIRTHPLACE (State or foreign country) <i>D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Stephen Tilley</i>		14. MOTHER'S MAIDEN NAME <i>MARY Jane Sherriff</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>(If yes, give war or dates of service)</i>	
17. INFORMANT <i>Daughter - Chart</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Tracheal Obstruction - Asphyxiation from</i> <i>334X</i> DUE TO <i>aspiration of vomitus.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral vascular Arteriosclerosis - Severe Emphysema</i> DUE TO <i>Several years.</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1-2 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1950</i> , to <i>Jan 9</i> , 1959, that I last saw the deceased alive on <i>Jan 9</i> , 1959, and that death occurred at <i>11:05</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>7105 Ridge Rd. Hyattsville, Md.</i> DATE SIGNED			
ACTUAL SIGNATURE <i>Robert B. Irey</i> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>ROBERT B. IREY</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>1/12/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Congressional Cemetery Washington, D.C.</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Sherriff Co.</i> ADDRESS <i>3901-14th St. N.W. D.C.</i>		24a. REC'D BY REGISTRAR <i>JAN 12 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

943

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				d. STREET ADDRESS Rt. #1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First JACOB Middle --- Last TRATEN		4. DATE OF DEATH		Month JANUARY Day 5 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 31, 1897		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ANTIQUE SHOP OWNER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fischer Trachtenberg				14. MOTHER'S MAIDEN NAME Esther Libby Frenkel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT JEANETTE R. TRATEN Address SAME			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1/2 HOUR
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at DOA M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE A. D. Bonifant M.D. Sandy Spring, Md 1/5/59 PHYSICIAN'S NAME (Type) A.D. BONIFANT, M. D. SANDY SPRING, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-7-59		22c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden		22d. LOCATION (City, town, or county) (State) Falls Church Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS B. Denzansky & Sons-3501 14th St., N.W., Wash., D.C.				24a. REC'D BY REGISTRAR DATE JAN 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0 10 20 30 40 50

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 56 Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2401 Spencer Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANK Middle V. Last TURNEY				4. DATE OF DEATH Month JANUARY Day 25 Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/7/1910	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rural Electrification-U.S. Gov't.		10b. KIND OF BUSINESS OR INDUSTRY Missouri	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Albert Thorn Turney		14. MOTHER'S MAIDEN NAME Ida E. Bethards	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 490-07-2150		17. INFORMANT Mrs. Nella Maud Turney-Silver Spring, Md.		Address 2401 Spencer Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF LUNG 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE						INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 11502 GRANDVIEW AVE.	
20f. (City or town) SILVER SPRING, MD.				20g. (County) MONTGOMERY		20h. (State) MD.	
21. I certify that I attended the deceased from OCT. 7, 1958 to JAN. 25, 1959 , that I last saw the deceased alive on JANUARY 25, 1959 , and that death occurred at 3:57 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Belden R. Reap				DATE SIGNED 1/25/59			
PHYSICIAN'S NAME (Type) BELDEN R. REAP M.D.				SILVER SPRING, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/28/1959		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				24a. REC'D BY REGISTRAR DATE JAN 27 '59		24b. REGISTRAR'S SIGNATURE Carlton E. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

NAME OF DECEASED

RESIDENCE

PLACE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

DIAGNOSIS

ICD-9 CODE

ICD-10 CODE

ICD-11 CODE

ICD-12 CODE

ICD-13 CODE

ICD-14 CODE

ICD-15 CODE

ICD-16 CODE

ICD-17 CODE

ICD-18 CODE

ICD-19 CODE

ICD-20 CODE

ICD-21 CODE

ICD-22 CODE

ICD-23 CODE

ICD-24 CODE

ICD-25 CODE

ICD-26 CODE

ICD-27 CODE

ICD-28 CODE

ICD-29 CODE

ICD-30 CODE

ICD-31 CODE

ICD-32 CODE

ICD-33 CODE

ICD-34 CODE

ICD-35 CODE

ICD-36 CODE

ICD-37 CODE

ICD-38 CODE

ICD-39 CODE

ICD-40 CODE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00947

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 38 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 4011 Dresden Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Howard Middle John Last Twilley		4. DATE OF DEATH Month January Day 15 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 23, 1904
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR: Months 10 Days 22 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food Inspector		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME S. S. Twilley		14. MOTHER'S MAIDEN NAME Anna Baumgartner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Viral Hepatitis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 8, 1958 , to January 15, 1959 , that I last saw the deceased alive on January 15, 1959 , and that death occurred at 9:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James C. Kirby, Jr. M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/15/59	
PHYSICIAN'S NAME (Type) James C. Kirby, Jr.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/17/59	22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	22d. LOCATION (City, town, or county) (State) Rockville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR JAN 19 59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

Date of Death JAN 13 1933		Place of Death Baltimore, Md.	
Name of Deceased John J. ...		Sex Male	
Age 38 years		Race White	
Date of Birth JAN 13 1895		Place of Birth ...	
Name of Physician ...		Name of Hospital ...	
Cause of Death ...		Manner of Death ...	
Signature of Physician ...		Signature of Registrar ...	

This certificate is valid only when filed in the office of the Registrar of the State Department of Health, Baltimore, Md.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>18 months</u>				d. STREET ADDRESS <u>4890 Battery Lane</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4890 Battery Lane Bethesda</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Gertrude Elizabeth Tyree</u>				4. DATE OF DEATH <u>Jan. 22 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 12, 1898</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk U.S. Gov't.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William A. Donaldson</u>				14. MOTHER'S MAIDEN NAME <u>Lovisa A. Plitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>W.W.I.</u>		17. INFORMANT <u>sister</u>		Address <u>Dorothy Hayden 826 South Irving Arlington, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>157X</u> DUE TO <u>gastrointestinal hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinomatosis</u> (c) <u>Carcinoma of pancreas</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 months</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 1958, to <u>Jan 22</u> , 1959, that I last saw the deceased alive on <u>Jan 21</u> , 1959, and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantraut</u> M.D.				ADDRESS (Street, city or town, state) <u>4890 Battery Lane Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Wilfred R. F. Ehrmantraut M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>				ADDRESS <u>2901 14th St. N.W. Washington, 9, D.C.</u>		24a. REC'D BY REGISTRAR <u>Jan 23 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED <i>William R. F. Farnsworth</i>		SEX <i>Male</i>		AGE <i>45</i>	
DATE OF DEATH <i>May 10, 1910</i>		TIME OF DEATH <i>10:30 A.M.</i>		PLACE OF DEATH <i>Home</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		PLACE OF BURIAL <i>St. Paul's Church</i>	
SIGNATURE OF PHYSICIAN <i>Wm. R. Farnsworth</i>		SIGNATURE OF MINISTER <i>Wm. R. Farnsworth</i>		SIGNATURE OF CORONER <i>Wm. R. Farnsworth</i>	
SIGNATURE OF DECEASED <i>Wm. R. Farnsworth</i>		SIGNATURE OF WITNESS <i>Wm. R. Farnsworth</i>		SIGNATURE OF WITNESS <i>Wm. R. Farnsworth</i>	

This is to certify that the above is a true and correct copy of the original as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 10th day of May, 1910.
 J. H. HARRIS, Registrar of Deaths, Baltimore, Maryland.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 days c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 318 Broadwood Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Michele Middle Mary Last Valleix		4. DATE OF DEATH Month January Day 2 Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/31/58
9. AGE (In years last birthday) 2		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis M. Valleix		14. MOTHER'S MAIDEN NAME Marguerite Patterson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Louis M. Valleix		Address 318 Broadwood Dr. Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 atelectasis DUE TO (b) Immaturity DUE TO (c) 48 hrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-31-58 , 19 58 , to 1-2 , 19 59 , that I last saw the deceased alive on 1-2-59 , 19 59 , and that death occurred at 9:30 PM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 809 Viers Mill Rd, Rockville Md		DATE SIGNED JAN 7 '59	
ACTUAL SIGNATURE Francis J. Troendle		PHYSICIAN'S NAME (Type) FRANCIS J. TROENDLE	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/6/59	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.		24a. REC'D BY REGISTRAR SILVER SPRING, MD.	
24b. REGISTRAR'S SIGNATURE Raymond A. Ziska		DATE JAN 7 '59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

948

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmo Sanatorium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Ann</u> Middle <u>Flanigan</u> Last <u>Detramile</u>				4. DATE OF DEATH <u>January 24</u> 19 <u>59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 6, 1874</u> 82 yrs.	
9. AGE (In years last birthday) <u>82</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Capt. A.P. Cunningham</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ida McCubbins</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Son, William F. Flanigan</u>		Address <u>10510 Insley St. Silver Spring, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized arteriosclerosis, diabetes mellitus</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour o. m. p. m.	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Jan 19, 1959</u> to <u>Jan 24, 1959</u> , that I last saw the deceased alive on <u>Jan 23, 1959</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.	
21. ADDRESS (Street, city or town, state) <u>Md</u>		21. DATE SIGNED <u>1/24/59</u>		ACTUAL SIGNATURE <u>Wilfred R. Ehrmantrout</u> M.D. <u>4890 Battery Lane, Bethesda</u>		PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantrout M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S.H. Hines</u>		ADDRESS <u>2901-14 St N.W.</u>		24a. REC'D BY REGISTRAR <u>Jan 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

FILE NO. 100

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

Robert L. Thompson

James L. Thompson

James L. Thompson
James L. Thompson
James L. Thompson

CERTIFICATE OF DEATH

Reg. Dist. No.

797

1. PLACE OF DEATH MONTGOMERY COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) P. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 26	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11706 Rockinghorse Road		d. STREET ADDRESS 11706 Rockinghorse Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARIE ROSE THERESA VINCENT		4. DATE OF DEATH Month Day Year January 12, 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1890
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 5 Days 7	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cisto Rossetti		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Anthony Vincent - as shown in #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Diphtheria mellitus			INTERVAL BETWEEN ONSET AND DEATH 1 hr 20 years 152 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Rockville		(County) (State)	
21. I certify that I attended the deceased from Oct 1954 , to 12 Jan 1959 , that I last saw the deceased alive on 9 Jan 1959 , and that death occurred at 1206 AM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 615 W. Montgomery Road, Rockville, Md.		DATE SIGNED 12 Jan 59	
ACTUAL SIGNATURE Dr. William S. Murphy			
PHYSICIAN'S NAME (Type) Dr. William S. Murphy, Rockville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-14-59	22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	22d. LOCATION (City, town, or county) (State) Silver Spring, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda 14, Md.		24a. REC'D BY REGISTRAR DATE JAN 14 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Knaus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1927

STATE OF MARYLAND		COUNTY OF BALTIMORE	
CITY OF BALTIMORE		WARD OF BALTIMORE	
DECEASED		AGE	
SEX		RACE	
BIRTH		DEATH	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL ATTENDANT	
CORONER		BURIAL	
FAMILY		RELATIONS	
OCCUPATION		EDUCATION	
MARRIAGE		CHILDREN	
SIBLINGS		PARENTS	
GRANDPARENTS		OTHER RELATIVES	
FRIENDS		NEIGHBORS	
TESTIMONY		SIGNATURE	
DATE		PLACE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

949

CERTIFICATE OF DEATH

00952

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY East Brady c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 75x-3 d. STREET ADDRESS R. D. #1, Box 211 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last John Andrew Vogt				4. DATE OF DEATH Month Day Year JANUARY 20, 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 18, 1943	
9. AGE (In years last birthday) 15 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Homer Vogt				14. MOTHER'S MAIDEN NAME Thelma Seybert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Expanding Brain Stem Tumor with secondary hemorrhage. 237x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) hemorrhage. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 11:00				20g. (County) 11:00		20h. (State) 11:00	
21. I certify that I attended the deceased from January 19, 1959 to January 20, 1959 , that I last saw the deceased alive on January 20, 1959 , and that death occurred at 11:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1-20-59 ACTUAL SIGNATURE Charles A. Bucknam, M.D. PHYSICIAN'S NAME (Type) Charles A. Bucknam, M. D. The National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/59		22c. NAME OF CEMETERY OR CREMATORY E. Brady Pa. Cem.		22d. LOCATION (City, town, or county) (State) E. Brady, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				24a. REC'D BY REGISTRAR JAN 23 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH JANUARY 26, 1957

DECEASED'S NAME (Print or Type) *Robert A. Johnson*

DATE OF BIRTH *1901*

SEX *Male*
 COLOR *White*
 HEIGHT *5' 10"*
 WEIGHT *175*

PLACE OF BIRTH *Baltimore, Maryland*

EDUCATION *High School Graduate*

OCCUPATION *Engineer*

RESIDENCE *1234 North Avenue, Baltimore, Maryland*

CAUSE OF DEATH *Myocardial Infarction*

SIGNATURE OF PHYSICIAN *Charles A. Johnson*

Robert A. Johnson, deceased, registered

950

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 9 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Stafford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83x-3 d. STREET ADDRESS RR #2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle (none) Last WALTERS			4. DATE OF DEATH Month January Day 23 Year 19 59				
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-86	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Marine Coprs		10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) Russia			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph WALTERS			14. MOTHER'S MAIDEN NAME Marie (unknown)				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1908-1935		16. SOCIAL SECURITY NO. 1908-1935		17. INFORMANT Official Navy Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Congestive heart failure DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Total Laryngectomy for advanced Carcinoma of Larynx 1-16-59					INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 14, 19 59 , to January 23, 19 59 , that I last saw the deceased alive on January 22, 19 59 , and that death occurred at 4:20A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE [Signature] M.D. U. S. Naval Hospital, NMMC			1-23-59				
PHYSICIAN'S NAME (Type) M. C. SHEA, LT, MC, USN			Bethesda 14, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-27-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National			
22d. LOCATION (City, town, or county) (State) Arlington Va.		24a. REC'D BY REGISTRAR DATE JAN 27 '59		24b. REGISTRAR'S SIGNATURE [Signature]			
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey Funeral Home, Bethesda, Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

959

WILLIAM IRONMID

WILLIAM IRONMID

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00954

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

787

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park		
c. LENGTH OF STAY IN lb 30 yrs			d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7324 Willow Ave.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			d. STREET ADDRESS 7324 Willow Ave.		
3. NAME OF DECEASED (Type or print) Roy Everett Walters			4. DATE OF DEATH Month Jan. Day 7, Year 1959		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/18/1884	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder			10b. KIND OF BUSINESS OR INDUSTRY Maryland		
11. BIRTHPLACE (State or foreign country) USA			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Geo. Washington Walters			14. MOTHER'S MAIDEN NAME Grimm		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Irene S. Walters (wife)			Address Item 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 42a1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart			DATE SIGNED 1/8/59		
EXAMINER'S NAME (Type) Frank J. Broschart			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 1/9/59.		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY	
22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, Md.		23. FUNERAL DIRECTOR'S SIGNATURE 254 CARROLL ST. N.W.			
24a. REC'D BY REGISTRAR DATE JAN 9 '59		24b. REGISTRAR'S SIGNATURE Charles S. Hanna			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00955

788

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>313 Ethan Allen Ave</u>				d. STREET ADDRESS <u>313 Ethan Allen Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>MAUD</u> First <u>WILKINS</u> Middle <u>WARGLE</u> Last		4. DATE OF DEATH <u>Jan - 1</u> Month <u>1</u> Day <u>19</u> Year <u>59</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 8 - 1878</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Wilkins</u>				14. MOTHER'S MAIDEN NAME <u>Thymante</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs. Estelle Woods</u> Address <u>313 Ethan Allen Ave</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of cervix</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>14 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. ft. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1954</u> , 19____, to <u>1/4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/2</u> , 19 <u>59</u> , and that death occurred at <u>7:45</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irving W. Winik</u> M.D. <u>3900</u>				DATE SIGNED <u>Washington 15 D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Irving W. Winik</u>							
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF <u>Jan 6, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Heller</u> ADDRESS <u>254 Carroll St. N.W. D.C.</u>				24. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>JAN 7 '59</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Dec 15, 1945</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SURVIVAL OF OTHERS <i>None</i>	
16. SIGNATURE OF DECEASED <i>John A. Smith</i>		17. SIGNATURE OF WITNESSES <i>John A. Smith</i>		18. SIGNATURE OF DECEASED <i>John A. Smith</i>	
19. SIGNATURE OF DECEASED <i>John A. Smith</i>		20. SIGNATURE OF WITNESSES <i>John A. Smith</i>		21. SIGNATURE OF DECEASED <i>John A. Smith</i>	
22. SIGNATURE OF DECEASED <i>John A. Smith</i>		23. SIGNATURE OF WITNESSES <i>John A. Smith</i>		24. SIGNATURE OF DECEASED <i>John A. Smith</i>	
25. SIGNATURE OF DECEASED <i>John A. Smith</i>		26. SIGNATURE OF WITNESSES <i>John A. Smith</i>		27. SIGNATURE OF DECEASED <i>John A. Smith</i>	
28. SIGNATURE OF DECEASED <i>John A. Smith</i>		29. SIGNATURE OF WITNESSES <i>John A. Smith</i>		30. SIGNATURE OF DECEASED <i>John A. Smith</i>	
31. SIGNATURE OF DECEASED <i>John A. Smith</i>		32. SIGNATURE OF WITNESSES <i>John A. Smith</i>		33. SIGNATURE OF DECEASED <i>John A. Smith</i>	
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37. SIGNATURE OF DECEASED <i>John A. Smith</i>		38. SIGNATURE OF WITNESSES <i>John A. Smith</i>		39. SIGNATURE OF DECEASED <i>John A. Smith</i>	
40. SIGNATURE OF DECEASED <i>John A. Smith</i>		41. SIGNATURE OF WITNESSES <i>John A. Smith</i>		42. SIGNATURE OF DECEASED <i>John A. Smith</i>	
43. SIGNATURE OF DECEASED <i>John A. Smith</i>		44. SIGNATURE OF WITNESSES <i>John A. Smith</i>		45. SIGNATURE OF DECEASED <i>John A. Smith</i>	
46. SIGNATURE OF DECEASED <i>John A. Smith</i>		47. SIGNATURE OF WITNESSES <i>John A. Smith</i>		48. SIGNATURE OF DECEASED <i>John A. Smith</i>	
49. SIGNATURE OF DECEASED <i>John A. Smith</i>		50. SIGNATURE OF WITNESSES <i>John A. Smith</i>		51. SIGNATURE OF DECEASED <i>John A. Smith</i>	
52. SIGNATURE OF DECEASED <i>John A. Smith</i>		53. SIGNATURE OF WITNESSES <i>John A. Smith</i>		54. SIGNATURE OF DECEASED <i>John A. Smith</i>	
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97. SIGNATURE OF DECEASED <i>John A. Smith</i>		98. SIGNATURE OF WITNESSES <i>John A. Smith</i>		99. SIGNATURE OF DECEASED <i>John A. Smith</i>	
100. SIGNATURE OF DECEASED <i>John A. Smith</i>		101. SIGNATURE OF WITNESSES <i>John A. Smith</i>		102. SIGNATURE OF DECEASED <i>John A. Smith</i>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

798

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 8 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 309 Frederick Ave., Lincoln Pk.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Peter Washington		4. DATE OF DEATH Month Jan Day 15 Year 1959	
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/15/1880
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Preacher		10b. KIND OF BUSINESS OR INDUSTRY Divine Healer	
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Peter Washington		14. MOTHER'S MAIDEN NAME Elizbeth Powell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Laura Washington (Wife)		Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Vascular Accident DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 day 8 Mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/18/59	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Park.,		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR DATE JAN 21 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

FOR STATE
HEALTH DEPT.

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BATHINGORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: _____

4. DATE OF DEATH: _____

5. TIME OF DEATH: _____

6. PLACE OF DEATH: _____

7. OCCUPATION: _____

8. CAUSE OF DEATH: _____

9. MANNER OF DEATH: ☐ NATURAL ☐ ACCIDENT ☐ SUICIDE ☐ HOMICIDE

10. SIGNATURE OF EXAMINER: _____

11. DATE OF EXAMINATION: _____

12. PLACE OF EXAMINATION: _____

13. NAME OF HOSPITAL: _____

14. NAME OF PHYSICIAN: _____

15. NAME OF NURSE: _____

16. NAME OF ATTENDING PHYSICIAN: _____

17. NAME OF SURGEON: _____

18. NAME OF DENTIST: _____

19. NAME OF OTHER HEALTH CARE PROVIDER: _____

20. NAME OF OTHER HEALTH CARE PROVIDER: _____

21. NAME OF OTHER HEALTH CARE PROVIDER: _____

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100. NAME OF OTHER HEALTH CARE PROVIDER: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00958

951

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co. Takoma Park, Md.</u> <u>Oakhaven Rest Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3702 Perry St Brentwood</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>517 Albany Avenue</u>		c. LENGTH OF STAY IN 1b <u>1634.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Tokoma Park, Md.</u>		d. STREET ADDRESS <u>3702 Perry St.</u>	
3. NAME OF DECEASED (Type or print) <u>Wells</u> First <u>George</u> Middle <u>H.</u> Last <u>Wells</u>		4. DATE OF DEATH <u>January 26</u> 19 <u>59</u> Month <u>36</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Aug 23, 1866</u> AGE (In years last birthday) <u>92</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Merchant Self</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Wells</u>		14. MOTHER'S MAIDEN NAME <u>Emma C. Sisson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>Unk.</u>	17. INFORMATION <u>Miss Jeanne Neg</u> Address <u>518 Carroll Ave NE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>4341</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1634.2</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 1.</u> Month <u>19</u> Day <u>19</u> Year <u>1959</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 19, 1959</u> to <u>Jan 26, 1959</u> , that I last saw the deceased alive on <u>Jan 26, 1959</u> , and that death occurred at <u>9:27 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip C. Jones</u> M.D.		ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive Silver Spring Md.</u>	
PHYSICIAN'S NAME (Type) <u>Philip E Jones</u>		DATE SIGNED <u>1-26-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-28-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Whitfield Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bonham Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Harcha Sons</u>		ADDRESS <u>Hatfield, Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Jones</u>	

CERTIFICATE OF DEATH

John Thompson taken
Age 2 Period of illness George Co

George
Age 2 1/2
Jan 22 1888
21.2

John Thompson
Age 2 1/2

Name of deceased		John Thompson	
Age		2 1/2	
Sex		Male	
Date of death		Jan 22 1888	
Place of death		George Co	
Cause of death		...	
Signature of physician		...	
Signature of registrar		...	
Signature of witness		...	
Signature of undertaker		...	
Signature of funeral home		...	
Signature of cemetery		...	
Signature of church		...	
Signature of school		...	
Signature of other		...	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

952

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4712 Edgefield Rd., Bethesda		e. STREET ADDRESS 4712 Edgefield Rd., Beth.	
3. NAME OF DECEASED (Type or print) First Sarah M. Middle WHEELER Last WHEELER		4. DATE OF DEATH Month Jan. Day 1, Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1872
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Month 11 Day 19	IF UNDER 24 HRS. Hours 11 Min. 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harmanus Bennett		14. MOTHER'S MAIDEN NAME Marion Collie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Marion S. Brooks - as above #2 Daughter		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary congestion, acute 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 hrs. 20 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 February 1956 to 1 January 59 , that I last saw the deceased alive on 31 Dec 1958 , and that death occurred at 12:05 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7659 Old Georgetown Road 1/2/59 Bethesda, Maryland			
ACTUAL SIGNATURE John M. Wyman, M. D.		M.D. 7659 Old Georgetown Road 1/2/59	
PHYSICIAN'S NAME (Type)		DATE	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-6-59	
22c. NAME OF CEMETERY OR CREMATORY Greenfield, Long Island - Long Island, N. Y.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JAN 5 '59	
24b. REGISTRAR'S SIGNATURE Charles E. Kraus			

CERTIFICATE OF DEATH

1952

NAME OF DECEASED [Illegible]		SEX [Illegible]		RACE [Illegible]	
DATE OF BIRTH [Illegible]		AGE [Illegible]		PLACE OF BIRTH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		MEDICAL ATTENDANT [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF CORONER [Illegible]		SIGNATURE OF JURY [Illegible]		SIGNATURE OF JUDGE [Illegible]	
SIGNATURE OF CLERK [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF DEPUTY REGISTRAR [Illegible]	

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00960

CERTIFICATE OF DEATH

953

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Montgomery		STATE Maryland		COUNTY Montgomery			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural Gaithersburg		LENGTH OF STAY (in this place) Life		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural Gaithersburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D. # 1		STREET ADDRESS (If rural give location) R.F.D. # 1 Live On Farm					
3. NAME OF DECEASED (First) (Middle) (Last) MARY WALTER WIGHTMAN				4. DATE OF DEATH (Month) (Day) (Year) Jan. 21 19 59			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Feb. 11 1874	9. AGE last birthday 84 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard H. Kinsey				14. MOTHER'S MAIDEN NAME Margaret Parsley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Clifton Wightman		2 Same As	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) Cerebral hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 5 days	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic cardiovascular disease						15 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6/12, 1949, to 11/21, 1959, that I last saw the deceased alive on 1/18, 1959, and that death occurred at M, from the causes and on the date stated above.							
SIGNATURE James P. Kerr M.D.				ADDRESS (Street, city, town, state) Homascus, Md.		DATE SIGNED 1/23/59	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan. 24		NAME OF CEMETERY OR CREMATORY Goshen		LOCATION (City, town, or county) (State) Goshen Md.	
24. REC'D BY REGISTRAR JAN 26 '59		REGISTRAR'S SIGNATURE Arthur L. Thomas		25. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber		ADDRESS Laytonsville	

100-10000

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

CERTIFICATE OF DEATH

Reg. Dist. No.

1933

PLACE OF DEATH		COUNTY	
BALTIMORE		BALTIMORE	
STREET		CITY	
1234		BALTIMORE	
STATE		ZIP	
MD		21201	
DATE OF DEATH		TIME OF DEATH	
JAN 15 1933		10:00 AM	
AGE		SEX	
45		M	
RACE		RELIGION	
W		C	
MARRIED		SINGLE	
YES		NO	
EDUCATION		OCCUPATION	
HIGH SCHOOL		CLERK	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
CORONARY ARTERY DISEASE		SUICIDE	
MURDER		ACCIDENT	
OTHER		OTHER	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. D. SMITH		A. B. JONES	
DATE		DATE	
JAN 15 1933		JAN 15 1933	
PLACE		PLACE	
BALTIMORE		BALTIMORE	
STATE		STATE	
MD		MD	

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased.

2. The cause of death should be stated in full, and the manner of death should be stated as natural, suicide, accident, or murder.

3. The signature of the physician or other qualified person must be written in ink.

4. The date and place of death must be stated.

5. The certificate should be filed in the office of the Registrar of the State Department of Health.

6. A copy of the certificate should be sent to the local health officer.

7. A copy of the certificate should be sent to the family of the deceased.

8. A copy of the certificate should be sent to the funeral home.

9. A copy of the certificate should be sent to the coroner.

10. A copy of the certificate should be sent to the police.

954 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Michigan b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 252 State Park Drive	
3. NAME OF DECEASED (Type or print) First Kim Middle Anne Last Wilcox		4. DATE OF DEATH Month January Day 26 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 22, 1958
9. AGE (In years last birthday) yrs. 11		IF UNDER 1 YEAR 11 Months 11 Days 4 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY Michigan	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Merle J. Wilcox		14. MOTHER'S MAIDEN NAME Kay B. Schulz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aplastic Anemia 292.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 10 , 19 59 , to January 26 , 19 59 , that I last saw the deceased alive on January 26 , 19 59 , and that death occurred at 2:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/26/59 ACTUAL SIGNATURE G. Richard Lee M.D. M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) G. Richard Lee, M.D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit	22b. DATE THEREOF 1/27/59	22c. NAME OF CEMETERY OR CREMATORY Maple Grove	22d. LOCATION (City, town, or county) (State) Empire, Michigan
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JAN 28 59	24b. REGISTRAR'S SIGNATURE <i>Conrad S. ...</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

789

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>WASH. D.C.</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C. 47x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>				d. STREET ADDRESS <u>4442-TINDALL ST. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>Sophia</u> Last <u>Will</u>				4. DATE OF DEATH Month <u>1</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-1-79</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>18</u> Hours <u>—</u> Min. <u>—</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Will</u>				14. MOTHER'S MAIDEN NAME <u>Cecelia Matson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hospital Records</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Congestive Cardiac Failure</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular Accident</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>19</u> p. m.	Month <u>—</u> Day <u>—</u> Year <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>3</u> , 19 <u>47</u> , to <u>1-19-59</u> , that I last saw the deceased alive on <u>1-18-59</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.							DATE SIGNED <u>1/19/59</u>
ACTUAL SIGNATURE <u>Robert A. Hare MD.</u>				ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Hare MD.</u>				ADDRESS <u>Takoma Park, Md.</u>			
22a. BURIAL <u>BURIAL</u>	22b. DATE THEREOF <u>1-21-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		22d. LOCATION (City, town, or county) (State) <u>AS+E S.E. Wash. DC</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Matthias W. Hyung Co.</u>				24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
ADDRESS <u>1300-N.W. N.W.</u>				DATE <u>JAN 20 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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 100-100-100
 100-100-100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film G238 1-28-59 et

CERTIFICATE OF DEATH

00963

Reg. Dist. No.

955

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ammon's Rest Home				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lula First Williams Middle Williams Last				4. DATE OF DEATH Month January Day 8 Year 1959			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 16, 1891		9. AGE (In years lost birthday) yrs. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Singleton Brown				14. MOTHER'S MAIDEN NAME Laura Simms			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Estelle Palmer Address Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Acidosis & Dehydration 260x DUE TO Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Carcinoma of the Breast (c) Carcinoma of the Breast							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiorenal Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 12, 1945 , to Jan. 8, 1959 , that I last saw the deceased alive on Jan 8, 1959 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Webster Sewell M.D.				PHYSICIAN'S NAME (Type) Webster Sewell Norbeck, Rt. 1 Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/13/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant.,		22d. LOCATION (City, town, or county) (State) Norbeck, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sunder ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR DATE JAN 15 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

NAME OF DECEASED		DATE OF DEATH	
JAMES M. SMITH		JAN 15, 1901	
AGE		SEX	
65		M	
RACE		RELIGION	
W		M	
BIRTH PLACE		PLACE OF BIRTH	
BALTIMORE, MD		BALTIMORE, MD	
DATE OF BIRTH		PLACE OF BIRTH	
JAN 15, 1836		BALTIMORE, MD	
CAUSE OF DEATH		PLACE OF DEATH	
HEART DISEASE		BALTIMORE, MD	
MANNER OF DEATH		PLACE OF DEATH	
NATURAL		BALTIMORE, MD	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DEATH REGISTRAR	
J. M. SMITH		J. M. SMITH	
DATE		DATE	
JAN 15, 1901		JAN 15, 1901	
PLACE OF DEATH		PLACE OF DEATH	
BALTIMORE, MD		BALTIMORE, MD	
NAME OF DECEASED		DATE OF DEATH	
JAMES M. SMITH		JAN 15, 1901	
AGE		SEX	
65		M	
RACE		RELIGION	
W		M	
BIRTH PLACE		PLACE OF BIRTH	
BALTIMORE, MD		BALTIMORE, MD	
DATE OF BIRTH		PLACE OF BIRTH	
JAN 15, 1836		BALTIMORE, MD	
CAUSE OF DEATH		PLACE OF DEATH	
HEART DISEASE		BALTIMORE, MD	
MANNER OF DEATH		PLACE OF DEATH	
NATURAL		BALTIMORE, MD	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DEATH REGISTRAR	
J. M. SMITH		J. M. SMITH	
DATE		DATE	
JAN 15, 1901		JAN 15, 1901	
PLACE OF DEATH		PLACE OF DEATH	
BALTIMORE, MD		BALTIMORE, MD	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Garden Sanitarium		d. STREET ADDRESS 4201 Mass. Ave. N.W. Apt 1037	
3. NAME OF DECEASED (Type or print) First Daisy Middle B. Last Wooten		4. DATE OF DEATH Month January Day 31 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/25/1883
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Miss.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vincey Brister		14. MOTHER'S MAIDEN NAME Julia Sutton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Lynell W. Littlefield, 4201 Mass. Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Endo Cervix DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Terminal Congestive Heart Failure DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Prob. 4 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 16 , 19 57 , to Jan. 31 , 19 59 , that I last saw the deceased alive on Dec. 29 , 19 59 , and that death occurred at 1:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2101 R St. N.W. - D.C. 8 DATE SIGNED			
ACTUAL SIGNATURE Leland E. Stevenson M.D.		M.D. 2101 R St. N.W. - D.C. 8	
PHYSICIAN'S NAME (Type) Leland E. Stevenson, M.D.		2101 R Street, N.W., Washington 8, D. C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal	22b. DATE THEREOF 1/31/59	22c. NAME OF CEMETERY OR CREMATORY Roseland Park Cemetery	22d. LOCATION (City, town, or county) (State) Hattiesburg, Miss.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St. N.W. Wash,		24a. REC'D BY REGISTRAR DATE FEB 2 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kinn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(continued)

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN 1b 21 HRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X GAITHERS BURG	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL				d. STREET ADDRESS 8 ROSEMONT DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bruce Roy First Middle Last BOY WORKINGER -- Twin II				4. DATE OF DEATH		Month Jan Day 28 Year 1959	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 27, 1959	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
						12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THEODORE RAY WORKINGER				14. MOTHER'S MAIDEN NAME ELAINE M. ERICKSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. —		17. INFORMANT FATHER Address ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity DUE TO — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO — (c) —						INTERVAL BETWEEN ONSET AND DEATH 21 Mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 27, 1959 to Jan 28, 1959 , that I last saw the deceased alive on Jan 28, 1959 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. N. Bergstom				ADDRESS (Street, city or town, state) Rockville Medical Center, Rockville DATE SIGNED Jan 28 '59			
PHYSICIAN'S NAME (Type) R. N. Bergstom				Rockville Medical Center Rockville Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 2-6-59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home ADDRESS 4748 Wis Ave. N.W. Washington D.C.				24a. REC'D BY REGISTRAR FEB 3 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kline	

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2274334XV2

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 65		4. DATE OF BIRTH Jan 15, 1885	
5. PLACE OF BIRTH New York City		6. OCCUPATION Retired	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE Jan 15, 1910	
9. NAME OF SPOUSE Mary H. Harris		10. DATE OF DEATH Jan 15, 1950	
11. PLACE OF DEATH Home		12. CAUSE OF DEATH Heart Disease	
13. SIGNATURE OF PHYSICIAN J. H. Harris		14. SIGNATURE OF WITNESSES J. H. Harris, Mary H. Harris	
15. SIGNATURE OF REGISTRAR J. H. Harris		16. SIGNATURE OF CLERK J. H. Harris	
17. SIGNATURE OF CHURCH CLERK J. H. Harris		18. SIGNATURE OF FUNERAL HOME J. H. Harris	
19. SIGNATURE OF BURIAL PLACE J. H. Harris		20. SIGNATURE OF INTERMENT J. H. Harris	
21. SIGNATURE OF CEMETERY J. H. Harris		22. SIGNATURE OF GRAVE J. H. Harris	
23. SIGNATURE OF MONUMENT J. H. Harris		24. SIGNATURE OF PLANTING J. H. Harris	
25. SIGNATURE OF PLANTING J. H. Harris		26. SIGNATURE OF PLANTING J. H. Harris	
27. SIGNATURE OF PLANTING J. H. Harris		28. SIGNATURE OF PLANTING J. H. Harris	
29. SIGNATURE OF PLANTING J. H. Harris		30. SIGNATURE OF PLANTING J. H. Harris	
31. SIGNATURE OF PLANTING J. H. Harris		32. SIGNATURE OF PLANTING J. H. Harris	
33. SIGNATURE OF PLANTING J. H. Harris		34. SIGNATURE OF PLANTING J. H. Harris	
35. SIGNATURE OF PLANTING J. H. Harris		36. SIGNATURE OF PLANTING J. H. Harris	
37. SIGNATURE OF PLANTING J. H. Harris		38. SIGNATURE OF PLANTING J. H. Harris	
39. SIGNATURE OF PLANTING J. H. Harris		40. SIGNATURE OF PLANTING J. H. Harris	
41. SIGNATURE OF PLANTING J. H. Harris		42. SIGNATURE OF PLANTING J. H. Harris	
43. SIGNATURE OF PLANTING J. H. Harris		44. SIGNATURE OF PLANTING J. H. Harris	
45. SIGNATURE OF PLANTING J. H. Harris		46. SIGNATURE OF PLANTING J. H. Harris	
47. SIGNATURE OF PLANTING J. H. Harris		48. SIGNATURE OF PLANTING J. H. Harris	
49. SIGNATURE OF PLANTING J. H. Harris		50. SIGNATURE OF PLANTING J. H. Harris	
51. SIGNATURE OF PLANTING J. H. Harris		52. SIGNATURE OF PLANTING J. H. Harris	
53. SIGNATURE OF PLANTING J. H. Harris		54. SIGNATURE OF PLANTING J. H. Harris	
55. SIGNATURE OF PLANTING J. H. Harris		56. SIGNATURE OF PLANTING J. H. Harris	
57. SIGNATURE OF PLANTING J. H. Harris		58. SIGNATURE OF PLANTING J. H. Harris	
59. SIGNATURE OF PLANTING J. H. Harris		60. SIGNATURE OF PLANTING J. H. Harris	
61. SIGNATURE OF PLANTING J. H. Harris		62. SIGNATURE OF PLANTING J. H. Harris	
63. SIGNATURE OF PLANTING J. H. Harris		64. SIGNATURE OF PLANTING J. H. Harris	
65. SIGNATURE OF PLANTING J. H. Harris		66. SIGNATURE OF PLANTING J. H. Harris	
67. SIGNATURE OF PLANTING J. H. Harris		68. SIGNATURE OF PLANTING J. H. Harris	
69. SIGNATURE OF PLANTING J. H. Harris		70. SIGNATURE OF PLANTING J. H. Harris	
71. SIGNATURE OF PLANTING J. H. Harris		72. SIGNATURE OF PLANTING J. H. Harris	
73. SIGNATURE OF PLANTING J. H. Harris		74. SIGNATURE OF PLANTING J. H. Harris	
75. SIGNATURE OF PLANTING J. H. Harris		76. SIGNATURE OF PLANTING J. H. Harris	
77. SIGNATURE OF PLANTING J. H. Harris		78. SIGNATURE OF PLANTING J. H. Harris	
79. SIGNATURE OF PLANTING J. H. Harris		80. SIGNATURE OF PLANTING J. H. Harris	
81. SIGNATURE OF PLANTING J. H. Harris		82. SIGNATURE OF PLANTING J. H. Harris	
83. SIGNATURE OF PLANTING J. H. Harris		84. SIGNATURE OF PLANTING J. H. Harris	
85. SIGNATURE OF PLANTING J. H. Harris		86. SIGNATURE OF PLANTING J. H. Harris	
87. SIGNATURE OF PLANTING J. H. Harris		88. SIGNATURE OF PLANTING J. H. Harris	
89. SIGNATURE OF PLANTING J. H. Harris		90. SIGNATURE OF PLANTING J. H. Harris	
91. SIGNATURE OF PLANTING J. H. Harris		92. SIGNATURE OF PLANTING J. H. Harris	
93. SIGNATURE OF PLANTING J. H. Harris		94. SIGNATURE OF PLANTING J. H. Harris	
95. SIGNATURE OF PLANTING J. H. Harris		96. SIGNATURE OF PLANTING J. H. Harris	
97. SIGNATURE OF PLANTING J. H. Harris		98. SIGNATURE OF PLANTING J. H. Harris	
99. SIGNATURE OF PLANTING J. H. Harris		100. SIGNATURE OF PLANTING J. H. Harris	

CERTIFICATE OF DEATH

Reg. Dist. No. 215

958

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 9 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun d. STREET ADDRESS Kepple Hills e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Karen Frances WORLAND				4. DATE OF DEATH Month Day Year January 16 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-5-59	
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Bainbridge, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Wallace WORLAND				14. MOTHER'S MAIDEN NAME Louise PRESLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tracheo esophageal fistula 756.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 11 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 7 , 19 59 , to January 16 , 19 59 , that I last saw the deceased alive on January 16 , 19 59 , and that death occurred at 10:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital DATE SIGNED 1-17-59 ACTUAL SIGNATURE E. J. Rupnik M.D. PHYSICIAN'S NAME (Type) E. J. RUPNIK, LCDR, MC, USN Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-19-59		22c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		22d. LOCATION (City, town, or county) (State) Cecil Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey R.A. Pumphrey Funeral Home, Bethesda, Md.				24a. REC'D BY REGISTRAR DATE JAN 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00966

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12817 Georgia Ave</u>				d. STREET ADDRESS <u>112817 Georgia Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Viola French Youmans</u>				4. DATE OF DEATH Month Day Year <u>Jan 7 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar 19, 1883</u>		9. AGE (In years last birthday) <u>75</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Wisc</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CLARION A. Youmans</u>				14. MOTHER'S MAIDEN NAME <u>Nettie French</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT <u>Mrs Beth V. Sturdevant</u>		Address <u>Silver Spring Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. ft. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Nov 7, 1958</u> , to <u>Jan 7, 1959</u> , that I last saw the deceased alive on <u>Jan 7, 1959</u> , and that death occurred at <u>7:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Lawrence Avery</u>				ADDRESS (Street, city or town, state) <u>10110 Georgia Ave Silver Spring, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>John Lawrence Avery</u>				DATE SIGNED <u>Jan 7 '59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>1/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Paska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 12 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00968

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3312 W. Coquelin Terrace		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 3312 W. Coquelin Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Desmonde Middle H. Last Zimmisch		4. DATE OF DEATH Month Jan Day 15 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/28/80
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ---Harding		14. MOTHER'S MAIDEN NAME ---Coles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT C. Harding Zimmisch		Address same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. None 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/3 , 19 58 , to 1/13 , 19 59 , that I last saw the deceased alive on 1/13 , 19 59 , and that death occurred at 12 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John B. Umhau M.D.		ADDRESS (Street, city or town, state) 8805 Conn. Ave.	
PHYSICIAN'S NAME (Type) John B. Umhau		DATE SIGNED 1/15/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/17/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		24. REC'D BY REGISTRAR 2901 14th St. N. Washington 9, D.C.	
24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE	

